State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

28501

29d. Date signed (Month, Day, Year)

AUGUST 29, 1998

	- Chicago	100	1. Decedent's Nan	ne (First, Middle	, Last)								2. Dete of I		Dey	Year	3. Time of Deeth
	Physic /Medi		MARTINE	E MAERUT	HA POSE	Y							AUGUS			98	4:40 PM.
9	Exami		4a Facility Neme	(If not institution BLOCK L							4b. City, To MASO		ocation of De RING	1		ty of Death LES C	OUNTY
	Funeral Director		5. Social Security I	Number	6. Sex 1 □ M 2 🔀 F	7. Age	(In yrs. last	t birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	6. Date of I	Birth Day, Yes	ar)		plece (State or Foreign ntry) INGTON, D. (
			Usual Residence	of Decedent		1	40			_	1		DEC. 2	.0, 1	. , , , ,	JWASH	INGION, D.
	72 hours efter death with the Marylend natural', or frems 23a or 28e-f show see Examinet must be notified	Director	10e. Stete MD	10b. County  CHARL	FS		10c. City, T		cation							10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	r 28a-f	rec	10e. Street and Nu		Lio		MANO	LHOI	10f. Zip	Code				10g.	Citizen of	What Cou	ntry?
	3a or		4560 POR	יי דא דא פ	CO POAD				20	0662	)			IINT	תבח כ	ያጥ ለ ጥፑ ና	OF AMERICA
	Jeath Tre 2	Funeral	11. Maritel Stetus	(I IADAC	12. Was D	ecedent E	ver in U,S.	13. \				igin? (Sp	ecify Yes or I		14. Ra	ce - Americ	cen Indian,
020	urs efter dea M', or Nerns Describer m	by Fur		rried 2 Marri	ed 1 ☐ Ye	Forces? s 2X No Give r Dates:	0	in U,S. 13. Was Decedent of If Yes, specify C			an, Mexica Specity		Rican, etc.)	Black, White, etc.  Specify: BLACK			
Ö	2 hou	Pe		15. Decedent	s Educetion		1	6e. Deced	ent's Usua	I Occup	pation			16b.	. Kind of I	Business/In	dustry
21215-0020	within ene. then	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  1 2 TH  16. Decedent's Use (Give kind of life. DO NOT life. DO NOT NOT NEVER					OO NOT us	e retire	d)	st or won	ang		N/	A		
	be filed itel Hygi of other event, t	BeC	17. Father's Name		.ast)						1	er's Nam	e (First, Midd	lle, Maio	den Suma	ime)	
Maryland	Wente Mente or rice or rice	ToB	MERVIN E		in (Type Print)			19h Meilir	n Address	(Street			IZABETI				p Code)
N S	trau					,										35-24	
	s 1 and 2 f Health ftem 27 i		JUANITA 20a. Method of Dis		(SISTER	)	20b. Plac	e of Dispo	sition (Nam	ne of		NTON	MARY Date			- City or T	
Baltimore,	permit. Peges Depertment of I important: If its any Injury or o		1 X Burial 2	☐ Cremation 5 ☐ Other (Sp		om Stete	cem	etery, cren	natory or of	her pla		т. 9	/4/98	PHI	ILADI	ELPHIA	A, PA
Ball	Depending the population of th		21. Signature of	rungstel Service L	attin	NE		LAV	VRENCI	E W.	PLU	NKET'	Γ, INC ,WASH.	. FU	NERA	L HOM	E 413
	3 1 0		23a. Pert1. Enter	the diseese, or art failure. List	complications the	at ceused	the death.	Do not ent	er the mode	e of dyl	ng, such as	cerdiac	or respiratory	errest,	4 40	010 1	Approximete Interval Between
	Physician	П	SHOOK, OF HO	an randro. Else	only one oddae o	04011 1111											Onset and Death
	/Medical	п	Immediate Cause disease or conditi	(Final	MUL	TIPLE	E INJ	URIES	3							1	
	Examiner		resulting in death)		a	(	Due to (or a	s a conseq	uence of):								
i.	D #	ne															
	be executed sician end buriel-trensit	Examiner	Sequentially list of	onditions,	Ь		Due to (or as	s a conseq	uence of):							1	
oʻ	an el uriel-t	Ä	Sequentially list c if any, leeding to I ceuse. Enter Und Cause (Disease o that initiated even	mmediate lerlying													
Box 68760,	nte be nysici	edicai	that initiated even resulting in death)	or Injury ts	c	c. Due to (or as a consequence of):											
99	eth certificate I stending physi for use es the I	Med	resulting in death)	Last												F I	
õ	endii r use	Par.			d					-						1	
-	The law requires that the deeth certificate be executed the has been signed by the ettending physician end pege 2 should be deteched for use es the buriel-tensit	Physician/M	Part II. Other sign	ificant condition	ns contributing to	death but	t not resultir	ng in the u	nderlying co	euse gi	ven in Part	l.	23b. D	ld tobac	co uae c	ontribute t	to the cause of death?
P.0		hy											1	☐ Yes	Yes 2□ No 3□ Probably 4♥Un		bably 4 🛚 Unknow
		by															
Vital Records,	v require been si												24a. W	as an au	utopsy	24b. W	Vere eutopsy findings vallable prior to
S	aw requisite the second	Completed												PECT		CC	ompletion of cause i death?
A.	The law ate has pege 2	E													2X No	1	☐ Yes 2☐ No
a			25. Was cese refe	erred to medical							26 Plea	e of Dea	th (Check on				
5		To Be	examiner?		Hospital:	☐ Inpatier	ot 2□ EB	Mutnation	t 3 DO	A Ot	hor		ome 5 R		6VV	ther /Sneci	AT
o			27. Menner of Dee		28a Di	ste of Injury			Approx2			urang re	28d. Describ				SCENE
o G	ding F th. After s funer	to	1 Natural	5 Pending investig		tonth, play	Yeer)	120	M W	1 [	rk? Yes 25	No	Passeng	er c	+ m	etor v	epicle that
Division	il or Attending safter deeth. I Director: After d in by the fune	fice	2 Accident 3 Suicide 6 Could niced 28e Place of Injury - At home, farm, street, factory,						, office	1		281. Location	n (Stran	t end Nur	nber or Rur	ral Route Number,	
Ö	i Diffic	Certification:	4  Homicide	55.57111	Sibo	illding, etc.	(Specify)	2 1 000	Man	5+	on p	2 (2)	4) City or		arle	s Ca	Md-
	ours eral		29a. Certifier	1 Certifying	Phyaician: To	the best of	f my knowle	dge, death	occurred	at the ti	me, date a	nd place	and due to the	he cause	e(s) end i	menner as	steted.
	Hos 24 h Fun etely	dical	(Check only one)	2XXMedical	xaminer: On the	basis of	examination	and/or Inv	estigetion,	in my	oplnion, de	ath occu	rred at the tim	e, dete	and place	e, and due t	o the cause(s)

State Registrar

31. Date filed (Month, Dey, Year) SEP 0 1 1998

JOSEPH PESTANER, M.D.

29b. Signature end title of certifier

32/Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

29c. License number

O.C.M.E.

95. 4. 4.33

		1. Decedent's Name (First, Middle,						2. Date of De		3. Time of Deeth
rysician Medical	_	JOHN	P	ROU	T			A49	29 /	998 1525
kaminer	_	4a. Facility Neme (If not institution, g	give street end numb	per)			4b. City, Town, or			
		SHADY GROVE	ADVENTI	ST H	OSPITA	L	ROCKVI	LLE	INOM	GOMERY
neral ector		218-16-0313	Sex 7.		lest birthday) _	if Under 1 Ye Months Da			ly, Year)	9. Birthplece (State or Foreign Country) 928 MARYLAND
_	-	Usual Residence of Decedent  10a. Stete 10b. County		10c. C	ity, Town or Loca	ation				10d. inside City Limits
0	5	MARYLAND MONTGO	MERY		ROCKVIL					1 ☐ Yes 2 No
by Funeral Director	מו מו מו	10e. Street and Number 299 HURLEY				10f. Zip Cod	20850		10g. Citizen of V USA	/hat Country?
by Funeral	Dy ruiter	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decede Armed Force 1 X Yes 2 If Yes, Give Year or Date	es? □ No	10	as Decedent of Yes, specify C	of Hispenic Origin? (Suban, Mexican, Puer No Specify:	Specify Yes or No to Rican, etc.)	14. Race Blace Specify	e - American Indian, k, White, etc.
Completed		15. Decedent's (Specify only highest s Elementary/Secondary (0-12)	Education		16a. Decede (Give ki		ne during most of wo tired)	orking	16b. Kind of Bu FED • GC	VT.
S	5				JET EN	GINE T	ECHNICIAN			AIR FORCE BAS
To Be Comp	2	17. Fether's Name (First, Middle, La JOHN S.	PROUT, SR	•				me (First, Middle	, Maiden Sumem PAREN	θ)
		19a. Informent's Name/Relationship					eet end Number or F			
	-	DOROTHY PROUT/	WIFE	100			LEN DRIVE			
5		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Special Content of the Content		140	Place of Disposi cemetery, creme CEDAR HI	itory or other	plece)	9-2-98		City or Town, State ID, MARYLAND
DOCE		21. Signature of Funeral Service Llo	ansee	axte			dress of Facility ${ m M}$			L HOME OF MD AND 20746
		23a. Part 1. Enter the disease, or co shock, or heart feilure. List on	mplications that cau ly one ceuse on eac	sed the dee h line.	th. Do not enter	the mode of	dying, such as cardia	c or respiretory e	rrast,	Approximate Interval Between
an	1			0			$\wedge$	1		Onset and Death
eai ner		Immediate Cause (Finel disease or condition resulting in death)	a	145	pirat	on	( neu z	none	Q.	13 days
ة ا		and an addition		Due to (	or es e consequ	ence of):				
Examiner			b			* 0				
Exa		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (	or as a conseque	ence of):				
edicai		that initiated events	C	Due to (	or es e conseque	ence of):				
		resulting in death) Last	d	500 10 (1	51 55 5 501156que					
icia		Part II. Other significant conditions	contributing to deat	h but not res	sulting in the und	erlying cause	given in Part I	23h Did	tohacco uas cor	tribute to the cause of death?
lieted by Physician/M		at it. Otto eiginicati sonditoria	contributing to death		salung in the and	enying cause	gwen in Fait i.		Yes 2 No	3 Probably 4 Unknown
Completed b								24e. Wes	an autopsy ormed?	24b. Were eutopsy findings available prior to completion of cause of death?
Comp								1 🗆	Yes 2 No	1 ☐ Yes 2 ☐ No
o Be		25. Wes case referred to medical examiner?					26. Place of De	ath (Check only	one)	
		1 ☐ Yes 2 Ø No  27. Menner of Death  1 Ø Natural 5 ☐ Pending	Hospital: 1 Inp 28a. Date of I (Month,		28b. Time of Injury	3LI DOA	Other: 4 Nursing I njury at Vork?	T	dence 6 Other	
Certification:		2 Accident investigati 3 Suicide 6 Could not determine	be 28e. Place of	Injury - At h	ome, farm, stree		Yes 2 No	28f. Location ( City or To	Street end Number	ar or Rural Route Number,
				etc. (Speci						
edicai		29a. Certifier 1 ☐ CertifyIng F (Check only one) 2 ☐ Medical Ex	Phyeiclan: To the be eminer: On the basis and manner	s of exemina	owledge, death o ation and/or inve	ccurred at the stigation, in m	time, dete end plec y opinion, deeth occ	e, end due to the urred at the time,	cause(s) end ma dete end piece, a	nner as stated. and due to the cause(s)
X X		29b. Signature end title of certifier	una mamier	June		29c. Lice	ense number		29d. Date signed	(Month, Day, Year)
		kr. Shak	is M	0		MA	27825	).	Ang 2	9 1996
	1		, ,			1	01000		1	1 110
	3	30. Name and address of person wh	o completed cause of	of death (ite	m 23a) (Type Dr	int)			0	
completely filled Medicai Ce		80. Name and address of person whe	CHAKIR	of death (ite	m 23a) (Type, Pr	SHAD	YGROVE	Ct,	PAITH	9 1998 ERS BYRG M 2087;

SEP 0 1 LLP JAL - LA

State of Maryland

Department of Health and Menta	al Hygiene
Certificate of Death	Reg. No.

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Physician	ı
/Medical	ļ.
Evaminar	1

1. Decedent's Name (First, Middle, Last)

2. Dete of Death Month

3. Time of Death

Physician	
/Medical	
Examiner	

**Funeral** Director

Directo Funeral

"natural", or items 23a or 28a-f ehow Completed

with the Maryland Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mantal Hygiene. Baltimore, Maryland 21215-0020 h and Mantal Hygiene.
7 ie marked other than "natur traumatic event, the Mantal nt of Health a if item 27 is or other tra permit. Page Department of Important: If any Injury or once.

> **Physician** /Medical Examiner

Examiner physician and the burial-transit The law requires that the death certificate be executed Physician/Medical 98 for use es signed by the e been sign Completed cartificata has b or Attending Physician: Be 10 this funeral Certification: ector 124 hours after the Funeral Direction of Funeral Directions of the Funeral Direction of the Funeral Property of the Funeral Pr Hospital To the Vithin 2 To 0

Division of Vital Records, P.O. Box 68760.

edicai State

LEROY POTTER AUGUST 26, 1998 9:05 PM. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Prince George's 8411 OXON HILL RD. OXON HILL 8. Dete of Birth 9. Birthplece (State or Foreign Month, Day, Year) 9. Virgin Islands If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In vrs. last birthday) 9. Birthplece (State or Foreign Deys Min Months Hours 65 Yrs. 580-01-5563 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Q Yes 2 □ No Maryland Prince George's Fort Washington 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 404 WILLOW WOOD COURT 20744 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Agned Forces? 1 1 Yes 2 □ No If Yes, Give Year or Dates: ARMY 14. Race - American Indian, 11 Marital Status Biack, White, etc. 1 Never Married 2 Married Specify: BLACK 1 Yes 2 No Specify: g 3 Widowed 4 Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Federal Government 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Potter James Adelia Fahie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Pnnt) Annie H. Potter wife 404 Willow Wood Ct. Fort Washington, MD 20744 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 9/1/98 Suitland, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility MARSHALL S FUNERAL HOME 21. Signature of Funeral Service Licenses 4308 Suitland Road Suitland, MD 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as e consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 Yes 2 No 3 Probably þ 24b. Were eutopsy findings available prior to completion of ceuse of deeth? 24a. Wes an autopsy performed?

25. Wes cese referred to medical examiner?

2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6XOther (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 28d. Describe how injury occurred 28c. Injury at Work?

1X Yes 2□ No 27. Manner of Deeth 28b. Time of Injury 28a. Dete of Injury (Month, Dev Year) 1 Natural 5 Pending (26/98 2 Accident investigation 1836HR 6 Could not be 3 ☐ Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

readwar Good Oxn Hell Ma 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the ceuse(s) and manner as stated. 2X Medicat Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end manner stated.

28f

29b. Signature end title of certifier

29c. License number O.X.M.E.

1 Yes 2 No

29d. Date signed (Month, Day, Year) AUGUST 27, 1998

While

2□ No

SCENE

RCE

30. Name and address of person who completed cause of beeth (Item 23e) (Type, Print) HOUSORE MIKEN

111 Penn Street, Baltimore, Maryland 21201

(Month, Day, Year) EP 0 1 1998 31. Date filed (Mor Registrar

4 Homicide

(Check only one)

29a. Certifier

Registrar's Signature Spall

1 1 3 3 3

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 28504 Certificate of Death 3. Time of Death 2. Data of Daath 1. Decedant's Name (First, Middla, Last) **Physician** 720 AUG /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number, Examiner SUBURBAN HOSPITAL MONTGOMERY If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. MAY 22, 1935 6. Sex 14 M 2 ☐ F 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** Months NORTH CAROLINA Yrs. 243-50-7490 63 Director Usual Rasidance of Decedent 10e State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 7 1/6 rai', or items 23s or 28s-f show 14 Yes 2□No Directo WASHINGTON DC the 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 20019 3728 D ST. S.E.#201 UNITED STATES Funeral Pages 1 and 2 should be filed within 72 hours efter death nent of Health and Mentel Hygiene.

ant: If item 27 is marked other than "natural", or itema 23 ury or other traumatic event, in "Medical Exertite many or other traumatic event, in "Medical Exertite many". 12. Was Dacedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Giva Yaar or Datas: 14. Race - Amarican Indien, Black, Whita, atc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 Navar Married 2 Married Specify: BLACK 1 ☐ Yas 2X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highast grada complated) Elamantery/Secondary (0-12) College (1-4or 5+) FED GOVERNMENT SUPPLY CLERK 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) BEN WARREN PAYTON SR. MISSIE DUNCAN 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) VALERIE GARVIN / DAUGHTER 3400 BRINKLEY RD APT 203 TEMPLE HILLS md 20748 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o XXBurial 2 ☐ Cramation 3 ☐ Removal from Stata 9-3-98 HARMONY MEMORIAL PARK LANDOVER, md 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Facility S. POPE FUNERAL HOME 21. Signatura of Funaral Service Licensee 23a. Part1. Enter the disease, or complications that causad the death. Do not anter the mode of dylng, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5538 MARLBORO PIKE FORESTVILLE, MD 20747 Approximata Intarval Batween Onsat and Daath **Physician** MYOCARDIAL INFARCTION /Medical Immediata Causa (Final diseasa or condition rasulting in death) Examiner Examiner physician and the bunal-transit The law requires that the death certificate be assecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Causa (Disease or injury that initiated avants resulting in deeth) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of). attending p signed by the a 23b. Did tobacco use contribute to the ceuse of death? Part II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Nuknown p 24b. Wera eutopsy findings available prior to Completed 24a. Was en eutopsy complation of cause of death? is certificate has I 1 Yas 2 Ne 1 ☐ Yas 2 ☐ No 25. Was cese rafarred to madicel examinar?

1/2 Yes 2 □ No Be 26. Placa of Daath (Chack only ona) Hospital: 1 ☐ Inpetiant 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 2 this 27. Mannar of Death 28b. Time of 28a. Data of Injury (Month, Day Yaar) 28c. Injury at Work? 28d. Dascribe how Injury occurred Certification: 5 Panding Investigation Natural 1 Tyes 2 No 2 Accident

8-27-9 or Attending Physician: Jue Paytou

To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu

Registrar

edical

1 Certifying Physicien: To the best of my knowledga, daath occurred at tha tima, date end place, and due to the cause(s) and mannar es steted.

2 Medical Examinar: On the basis of axeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and mannar stated. 290. Signature and title of bertifier

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

29c. Licansa number

29d. Data signed (Month, Day, Year)

28f. Location (Streat and Number or Rurel Routa Number, City or Town, Stata)

RO BETHESD.

30. Name and addrass of person who completed cause of death (Item 23e) (Type, Print)

10215 31. Date filed (Month, Day, Yaar) SEP 0 1 1998

6 Could not be detarmined

3 ☐ Suicide

29a. Cartifian (Check only one)

4 Thomicide

3. Registrar's Signatura

with the money was 10 years

And and the control

application of the first terms of the contract of the contract

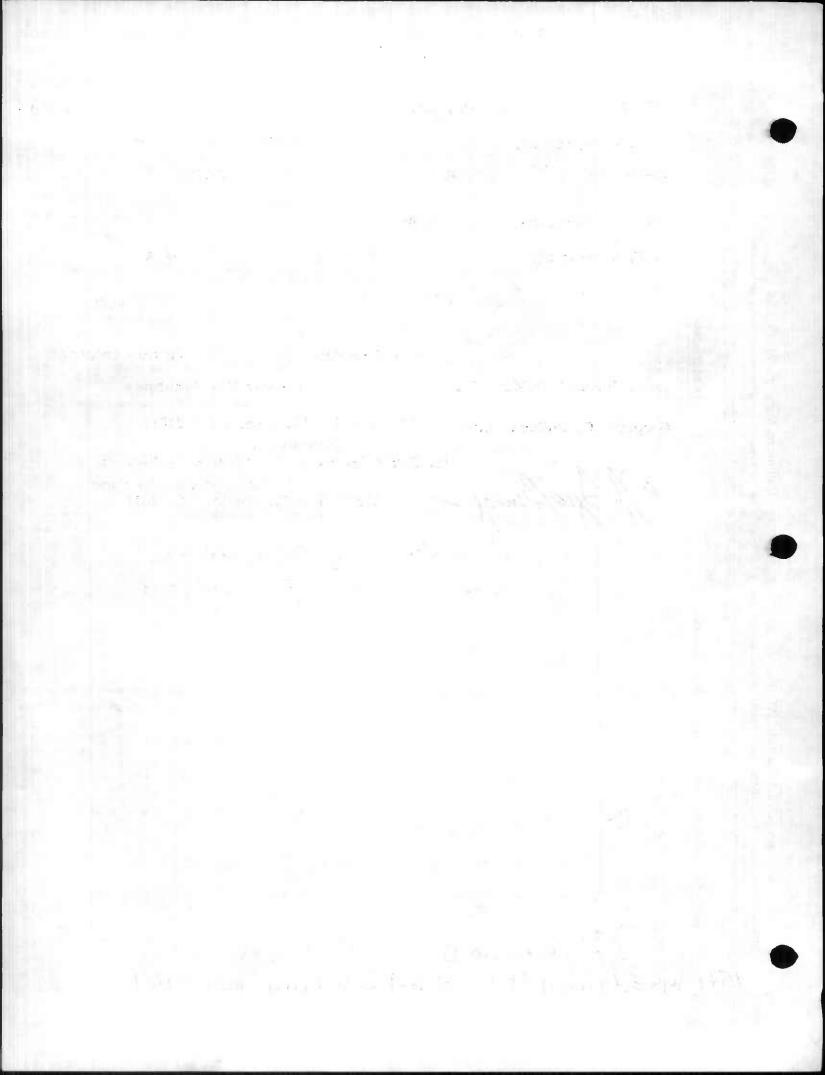
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** EDWARD PERCY PHILLIPS, SR. 8 26 98 8:30 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Worcester 9328 Decatur St. Berlin if Under 24 Hrs. Hours Min. If Undar 1 Year Birthplaca (Stete or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Dey, Year) 7. Age (In vrs. last birthday) **Funeral** Months XXM 2 F Days Yrs. Director 213-05-3155 80 4/22/18 Usual Residence of Decedent the Maryland 10d. fnside City Limits 10c. City, Town or Location 10a State 10b County r 28a-f show 1 XYes 2 No Director MD Worcester Berlin 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours efter death with 1 Department of Health and Mentel Hygiena. Important if item 27 is marked other than "natural", or items 23s or items 19 or other traumatic avent, the Massical Exercitive must be an any injury or other traumatic avent, the Massical Exercitive must be an any injury or other traumatic avent, the Massical Exercitive must be an account. 9328 Decatur St. 21811 USA Funeral 12. Was Decedanf Ever in U,S. Armed Forces? ↑ Tyes 2 □ No of Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Ricen, etc.) 14. Race - Amarican Indian. 11. Marital Status Black, White, etc. 1 ☐ Naver Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: py 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Coliana (1-4or 5+) Canning Company Vice President 5+ 18. Mother's Name (First, Middle, Maidan Surname) 17. Father's Nama (First, Middle, Last) James Richard Phillips, Jr. Audrey May Wimbrow 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Numbar, City or Town, Stete, Zip Code) 9328 Decatur St. Berlin, MD 21811 Margaret G. Phillips/ Wife 20b. Place of Disposition (Neme of cemetery, crematory or other property) 20c. Location - City or Town, Sfata 20a. Method of Disposition 1 Burial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) 8/30/98 Berlin, MD Paul's Episcopal 22. Name and Address of Facility Burbage Funeral Home 108 William St. Berlin, MD 21811 inta Approximata Interval Between Onset and Death led the death. Do not entar the mode of dying, such as cerdiac or respiratory arrest, **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be axecuted physician end s the burief-trans Sequentially list conditions, if any, leading to immadiata ceuse. Enter Underlying Causa (Disease or injury that initiated events rasulting in death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical Dua to (or as a consequence of): SBS attanding use ō signed by the a Part II. Other significant conditions contributing to death but not rasulting in the underlying ceusa given in Part I. 23h. Did tohacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to been si 24a. Was an autopsy performed? Completed completion of ceuse of daath? s cartificata has b director, page 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yas 2 ☐ No or Attending Physician: director, Be 25. Was cesa referred to medicel examiner? 26. Place of Daath (Check only ona) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) PENO Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Dey Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Natural 5 Pending 1 Yes 2 No death. Invasfigation 2 Accident after death Director: / d in by tha f 6 Could not be datarmined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 | Homicide 24 hours after Funeral Dire letaly filled in b Hospital Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

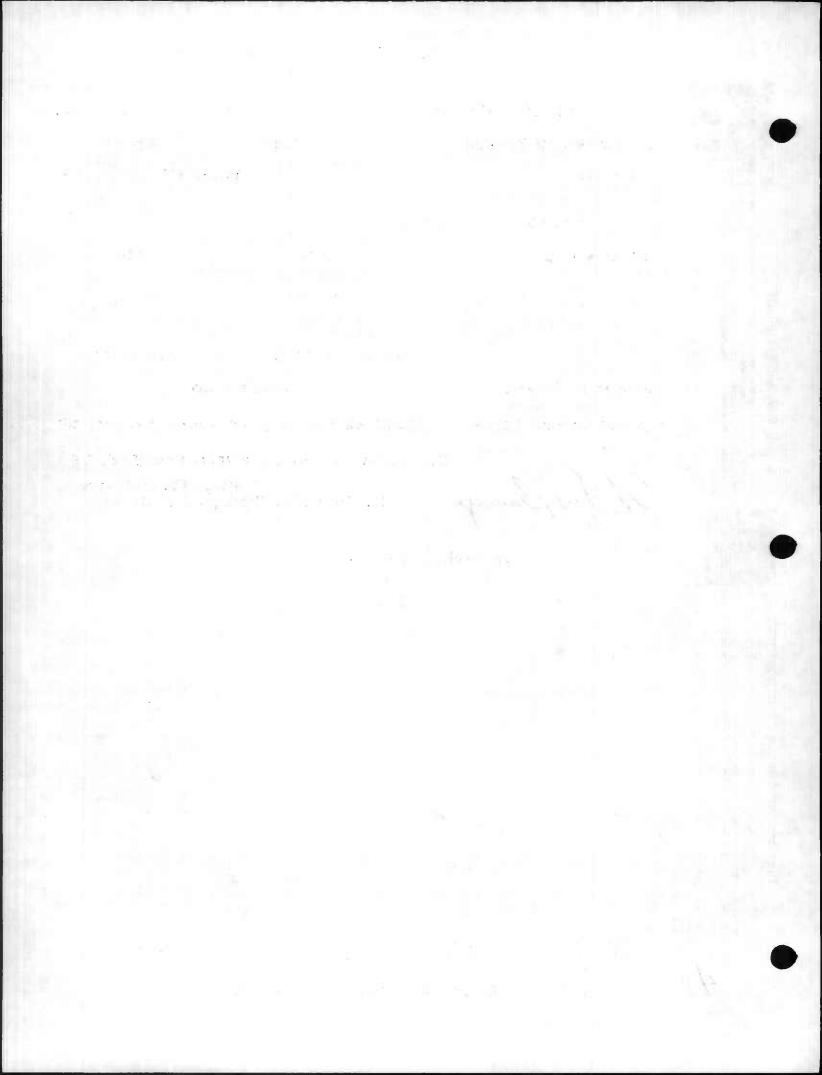
Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier edical To the Hosp within 24 hor To the Fune completaly fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 29c. License number 25 98 d cause of death (Item 23a) (Type, Print) 30. Nama and address 154 145 E 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

AUG 26



A Facility Name (Prior Institution, prior etrees and number)  Attantic General Hospital  S. Social Searchy Number  6. Sex 1 - Angle (n. yrs., hast birthology)  81 - Yrs.  10 - Copy Form or Location	### POYNTON ### devices the post of Death ### Hospital ### Worcester #### Worcester ##### Worcester ##### Worcester ##### Worcester ##### Worcester ##### Worcester ###### Worcester ####################################		1. 0	Decedent'a Nan	ne (First, Middle,	Last)			Certificat			2. Date of D			3. Time of Deal
Atlantic General Hospital  Atlantic General Hospital  Social Security Number  10. Specify  10. Specify  119-14-2459  110 M 28 F 7, App (h. yrs. last binnolly)  119-14-2459  110 M 28 F 7, App (h. yrs. last binnolly)  110 M 28 F 7, App (h. yrs. last binnolly)  110 M 28 F 7, App (h. yrs. last binnolly)  110 M 28 F 7, App (h. yrs. last binnolly)  110 M 28 F 7, App (h. yrs. last binnolly)  110 M 28 F 7, App (h. yrs. last binnolly)  110 M 28 F 7, App (h. yrs. last binnolly)  110 M 28 F 7, App (h. yrs. last binnolly)  110 M 28 F 7, App (h. yrs. last binnolly)  110 M 29 M 10 M 29 M 10 M 29 M 10 M 29 M 10 M 10 M 29 M 10 M 1	4. Cay, Town, or Location of Deeth   Worcester   Worcester   Work   Wo			BLANC	THE COL	BERT	POYN.	TON							5 · 26 A
Special Security Number   County   Taylor   1 may 280 F   Name of the property   Special Security   Taylor	1. Age (in yrs. lest brinday)   If Index 1 Yes.   If Index 24 Hrs.   B. Date of Birth (Month)   Days   Yes.		4a							4	4b. City, Town, or				
719-14-2459   1	10c. City, Town or Location   10d. Inside City Lim 10/27/ 1916   10d. Inside City Li		п	Atlan	tic Gene	ral Hos	spital						Wor		
T19-14-2459   State   Tips	10c. City, Town or Location   10d. Inside City Lim   10d. Inside C		5. S	Sociel Security I	Number 6				Months			(Month, D	irth ley, Year)	9. Birthp	olece (Stete or For
100. State   100. County   100. Colly, Town or Locality   100. Street and Number   100. Linking   100. Street and Number   100. Street and Number   100. Linking   1	100. Zip Code   100. Zip Code   100. Citizen of What Country?   218 42		Hen			12 101 2202 1	81		rrs.			10/27	/ 1916		VA
Top   State   Top   To	101. Zip Code   102. Zip Code   103. Citizen of What Country?   USA   1. Was Depositent Ever in U.S.   1. Was Depositent Ever in U.S.   1. Was Deposited College (1 - 10 - 10 - 10 - 10 - 10 - 10 - 10 -		-		1	61-61	10	c. City, Town	or Location					1	10d. Inside City Lin
11. Marital Status   12. Was Decident Ever in U.S., Armed Forces?   1. Wes Decident of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuber, Mexican, Puerio Rican, etc.)   1. ReoAmerican Indien Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify:	10f. Zip Code   21842   USA	0		MD	Word	ecter		Ocea	n City						1 XYes 2
11. Marital Status   12. Was Decident Ever in U.S., Armed Forces?   1. Wes Decident of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuber, Mexican, Puerio Rican, etc.)   1. ReoAmerican Indien Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black, White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify: White Black White, etc.   1. Wes 2 No. Specify:	Was Decedent Ever in U.S.   13. Was Decedent of Hispanic Ordon? (Specify Yes or No-Mire Process)   14. Race - American Inflam, Birth Wes, specify Cuben, Mexican, Puerfo Rican, etc.)   14. Race - American Inflam, Birth Wes, Gree 2g No 1   Yes 2g No Specify:   1   Yes 2g	2	10e			CSCI		Occa		Code			10g. Citizen of	What Cour	ntry?
11. Marital Status 12. Marital Status 13. Mere Decedent of Hispanic Origin? (Specify Yes or No. 11   Never Married 2   Married 30/2   Windowed 4   Divorce of Posts of Dales.  15. Decedent's Education (Specify or Origins)   10   Never Married 2   Married 30/2   Windowed 4   Divorce of Dales.  15. Decedent's Education (Specify or Origins)   10   Never Married 2   Married 30/2   Windowed 4   Divorce of Dales.  15. Decedent's Education (Specify or Origins)   10   Never Married 1   Never Married 1	Was Decedent Ever in U.S.   13. Was Decedent of Hispanic Ordon? (Specify Yes or No-Mire Process)   14. Race - American Inflam, Birth Wes, specify Cuben, Mexican, Puerfo Rican, etc.)   14. Race - American Inflam, Birth Wes, Gree 2g No 1   Yes 2g No Specify:   1   Yes 2g			424	Lark Lar	ne				218	342		1	ISA	
Tyes 29 No Specify:	1	5	11.			12. Was D	Decedent Ever	in U,S.	13. Wes Dece	dent of H	Hispanic Origin? (S	pecify Yes or N	lo- 14. Re	ce - Americ	
15. Decedent's Education (Specify only highest grade completed)   18e. Decedent's Usual Occupation (Specify only highest grade completed)   18e. Decedent's Usual Occupation (Specify only highest grade completed)   18e. Decedent's Usual Occupation (Specify only highest grade completed)   18e. Decedent's Usual Occupation (Specify only highest grade completed)   18e. Decedent's Usual Occupation   18e. Decedent   18e. Decedent   18e. Decedent's Usual Occupation   18e. Decedent   18e. Decedent   18e. Dec	White titles are consequence of:    Second   College (1-4or 5+)   18a. Decedent's Usual Occupation (Give kind of work done during most of working (Give kind of work done during most of working (Give kind of work done during most of working (Give kind of work done during most of working (Give kind of work done during most of working (Give kind of work done during most of working (Give kind of work done during most of working (Give kind o			1 Never Mar	ried 2 Married	d 1 □ Ye	es 2 No			-		o rican, etc./			etc.
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Raleigh F. Colbert    19a. Informart's Name (First, Middle, Lest)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	Second   S			(Spe	15. Decedent's ecify only highest	Education grade complete	ted)		(Give kind of wo	ork done	during most of wo	rking	16b. Kind of I	Business/in	dustry
Raleigh F. Colbert    19s. Informant's Name (First, Middle, Lest)     19s. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)     19s. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)     19s. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)     19s. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)     19s. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)     19s. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)     19s. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)     19s. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)     19s. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)     19s. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)     19s. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)     20c. Location - City or Town, State, Zip Code)     20c. Heart Indeed of Code of Pales     22s. Name and Address of Facility     19s. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)     22s. Name and Address of Facility     23s. Part Eries Its Gydns, or capitalists that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,     23s. Part Eries Its Gydns, or capitalists that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,     23s. Part Eries Its Gydns, or capitalists     23s. Did tobacco use contribution of deeth     23s. Did tobacco use contribution of deeth     24s. Wes an eutopsy performed?     24s.	18. Mother's Name (First, Middle, Meiden Sumeme)   Flossie Moore	-	E		ondary (0-12)	Colleg	ge (1-4or 5+)								
Raleigh F. Colbert    19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Mumber or Rural Route Number, City or Town, Stete, Zip Code)   139. Mailing Address (Street and Mumber or Rural Route Number, City or Town, Stete, Zip Code)   139. Mailing Address (Street and Mumber or Rural Route Number, City or Town, Stete, Zip Code)   139. Mailing Address (Street and Mumber or Rural Route Number, City or Town, Stete, Zip Code)   139. Mailing Address (Street and Mumber or Rural Route Number, City or Town, Stete, Zip Code)   139. Mailing Address (Street and Mumber or Rural Route Number, City or Town, Stete, Zip Code)   139. Mailing Address (Street and Mumber or Rural Route Number, City or Town, Stete, Zip Code)   139. Mailing Address (Street and Mumber or Rural Route Number, City or Town, Stete, Zip Code)   139. Mailing Address (Street and Mumber or Rural Route Number, City or Town, Stete, Zip Code)   139. Mailing Address (Street and Mumber or Rural Route Number, City or Town, Stete, Zip Code)   139. Mailing Address (Street and Mumber or Rural Route Number, City or Town, Stete, Zip Code)   139. Mailing Address (Street and Mumber or Rural Route Number, City or Town, Stete, Zip Code)   139. Mailing Address (Street and Mumber or Rural Route Number, City or Town, Stete, Zip Code)   139. Mailing Address (Street and Mumber or Rural Route Number, City or Town, Stete, Zip Code)   139. Mailing Address (Paper)   149. Mailing Address (Street and Mumber or Rural Route Number, City or Town, Stete, Zip Code)   149. Mailing Address (Paper)   149. M	Per   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)		17		/First Middle La	et)		1	Account	ant		ne /First Middl			g
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Raymond Colbert / Nephew  20a. Method of Disposition 1	Nephew   13922 King Gregory Way Upper Mariboro, MD 20   20c. Location - City or Town, State   20c. Place of Disposition (Neme of Cermetery, cremetory or other place)   Date   20c. Location - City or Town, State   20c. Location - City or Town, State   20c. Place of Disposition (Neme of Cermetery, cremetory or other place)   Date   20c. Location - City or Town, State   20c. Location - City or Town, State - City or Town,	-			~			19h	Mailing Address	s (Street				n Stete 7ir	Code)
20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery) cremetory or other place)   Date   20b. Location - City or Town, State		100												
Cape Henlopen Crematory8/28/98 Frankford, DE	Cape Henlopen Crematory 8/28/98 Frankford, DE  22. Name and Address of Facility Burbage Funera I Home 108 William St. Berlin, MD 21811  Approximate Interval Between cause on each line.  Due to (or as a consequence of):  23b. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Pert I.  23b. Did tobacco use contribute to the cause of death   1   Yes 2   No 3   Probably 4   Unkir   Yes 2   No   1   Y		20a					Ob. Place of	Disposition (Ne	me of					
21. Signature of Juntal Sprice Licensee  22. Name and Address of Facility  108 William St. Berlin, MD 21811  23a. Part Fine the durane, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximately an analysis of complete the mode of dying, such as cardiac or respiratory arrest.  Approximately list conditions, in the deeth of the mode of dying, such as cardiac or respiratory arrest.  Due to (or es a consequence of):  C. Due to (or es a consequence of):  Due to (or as a consequence of):  24a. Wes en eutopsy performed?  24b. Were autogically available propriet of the cause specified of deeth of the cause specified of the cause of t	22. Name and Address of Facility   Burbage Funeral Home   108 William St. Berlin, MD 21811						rom State					18/28/9	8 Frank	ford	DE
Burbage Funeral Home  108 William St. Berlin, MD 21811  23a. Part I. Enter the dynams, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, interval ones of the shock, or heart failure. List only one cause on each fineral ones to give as a consequence of the cause (Finel disease or condition resulting in death)  Due to (or es a consequence of):    Due to (or es a consequence of):	Burbage Funera   Home  108 William St. Berlin, MD 21811  Approximate interval Between cause on each line.  Approximate interval Between cause on each line.  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as e consequence of):  Due to (or as e consequence of):  23b. Did tobacco use contribute to the cause of de 1   Yes 2   Yes   Yes		21:					Cape			ss of Facility				
23a. Part I. Enter the discusse, or complications that caury'd the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, interval onset a shock or heart failure. List only one cause on each line.  Immediate Ceuse (Finel disease or condition resulting in deeth)  Due to (or es a consequence of):  Due to (or es a consequence of):  Due to (or as e consequenc	Approximate interval Between cause on each line with a cause of death. Do not enter the mode of dying, such as cardiac or respiretory arrest, interval Between Consett end Death Consett end Death Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as e consequence of):  23b. Did tobacco use contribute to the cause of death of the cause of the c				/ //	-						Burbage	e Funer	a I Ho	me
Immediate Ceuse (Finel disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if env, leading to immediate cause. Enter Underlying Ceuse (Disease or injury their inhieled events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Ceuse (Disease or injury their inhieled events resulting in death) Last  Due to (or as e consequence of):  Due to (or as e consequence of):  23b. Did tobacco use contribute to the cause of	Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a consequence of):			D H	14:1	16.	1		100 1	A/:					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.  23b. Did tobacco use contribute to the cause of the ca	ibuting to death but not resulting in the underlying cause given in Pert I.  23b. Did tobacco use contribute to the cause of de  1		lmr disc res	mediate Ceuse	(Finel	Implications the state of the s	nat caured the on each line.	deeth. Do n			am St. B	erlin, l	MD 2181		Approximate Interval Between
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24a. Wes en eutopsy performed?  24b. Were autopsy performed?  1	24a. Wes en eutopsy performed?  24b. Were autopsy findin aveilable prior to completion of cause of death?  1 Yes 2 No  26. Piece of Deeth (Check only one)  27 Set of Injury at Work?  28a. Dete of Injury (Month, Dey Year)  28b. Time of Injury at Work?  M 1 Yes 2 No  28c. Injury at Work?  M 1 Yes 2 No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Location (Street end Number or Rural Route Number, City or Town, Stete)	edicai	Sec if e cau	mediate Ceuse ease or conditi sulting in death) quentially list or my, leeding to in use. Enter Und use (Diseese trinitieted even	(Finel on	anplications the first one cause of the first	Myotare Due	to (or es a c	enter the modern the modern that the modern th	de of dyir	am St. B	erlin, l	MD 2181		Approximate Interval Between
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25. Wes case referred to medical examiner?  1	26. Place of Deeth (Check only one)  spital: 1   Inpatient 2   DER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)  28a. Dete of Injury   28b. Time of Injury   28b. Ti	by Physician/Medical	Seed of the cauchy of the cauc	mediate Ceuse ease or conditi sulting in death) quentially list or ny, leeding to it use. Enter Und use (Disesse of ti initiated eveni sulting in death)	(Finel on	a b c d	Due Due	o to (or as a c	consequence of):	de of dyir	am St. B	erlin, loc or respiretory  23b. Dia 10	d tobacco use c Yes 2500	tontribute t 3 Pro	Approximate Interval Between Onset end Death of the cause of de bably 4 Unknown Vereautops y findin (eilable prior formpletion of cause
examiner?  1   Yes 24 No	spital: 1   Inpetient 2   DER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)    28a. Dete of Injury (Month, Dey Year)   28b. Time of Injury at Work?   1   Yes 2   No    28e. Placa of Injury - At home, farm, street, factory, office   28f. Location (Street end Number or Rural Route Number, City or Town, Stete)    28e. Placa of Injury - At home, farm, street, factory, office   28f. Location (Street end Number or Rural Route Number, City or Town, Stete)    28e. Placa of Injury - At home, farm, street, factory, office   28f. Location (Street end Number or Rural Route Number, City or Town, Stete)	by Physician/Medical	Seed of the cauchy of the cauc	mediate Ceuse ease or conditi sulting in death) quentially list or ny, leeding to it use. Enter Und use (Disesse of ti initiated eveni sulting in death)	(Finel on	a b c d	Due Due	o to (or as a c	consequence of):	de of dyir	am St. B	erlin, it correspiretory  23b. Did 10  24a. We per	d tobacco use colors en eutopsy formed?	contribute t 3 Pro	Approximate Interval Between Conset end Death of the cause of de Deably 4 Unknown under the cause of death?
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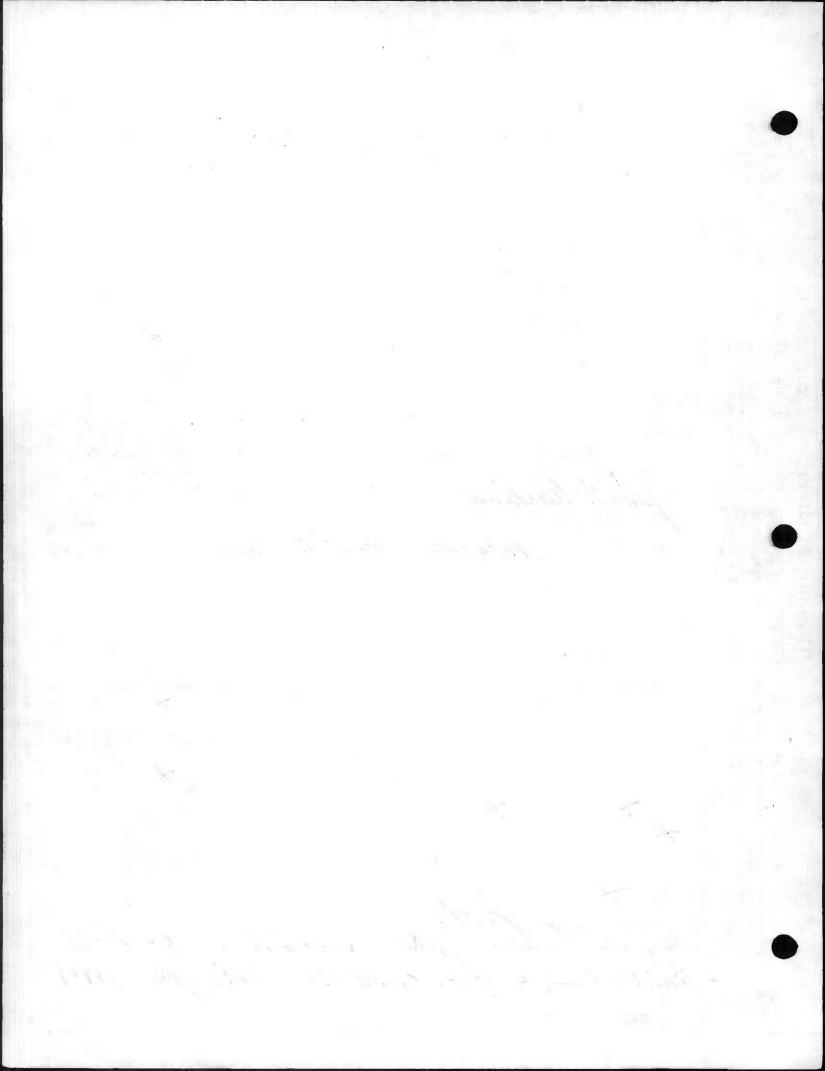


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Day **Physician** august 0905 Miriam Joy Pruitt Parks 25 1998 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Months Days Hours Min. 9/23/56 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 F 216-70-1877 41 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Insida City Limits VA. Tangier 1 XYas 2 No Accomack Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 23440 USA 4378 Lang Bridge Rd. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2X No If Yas, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Elemtary School Teacher Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) 89 Ments! Thomas Asbury Pruitt Ella Marie Dise 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4378 Lang Bridge Rd., Kim Allen Parks Tangier, VA. 23440 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata Department of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 8/30/98 Tangier, VA. New Testament Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Williams - Parksley F. H. 25046 Parksley Rd., Parksley, VA. 23421 11. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Physician Parotid Concer Immediata Causa (Final disease or condition resulting in death) Metastatic /Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury thal initiated events resulting in death) Last Dua to (or as a consequence of): P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown cata has been signed page 2 should be de Records, à 24b. Ware autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 ☐ Yas 1 ☐ Yas 2 ☐ No certificata Division of Vital Hospital or Attanding Physician: director, 25. Was casa refarred to medical 26. Place of Death (Check only one) 1 Yas 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Medical Certification: To this funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation 1 ☐ Yas 2 ☐ No 24 hours after death. To the Hospital or Attai within 24 hours after dei To the Funeral Directo completely filled in by th 6 Could not be 3 Suicide 28a. Place of Injury - At homa, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) and manner state. 29a. Certifier (Check only one) on and/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to tha cause(s) 29d. Data signed (Month, Day, Year), 29c. License number 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) E. Court MA 145E. 32. Registrar's Signature 31. Data liled (Month, Day, Year) State Registrar

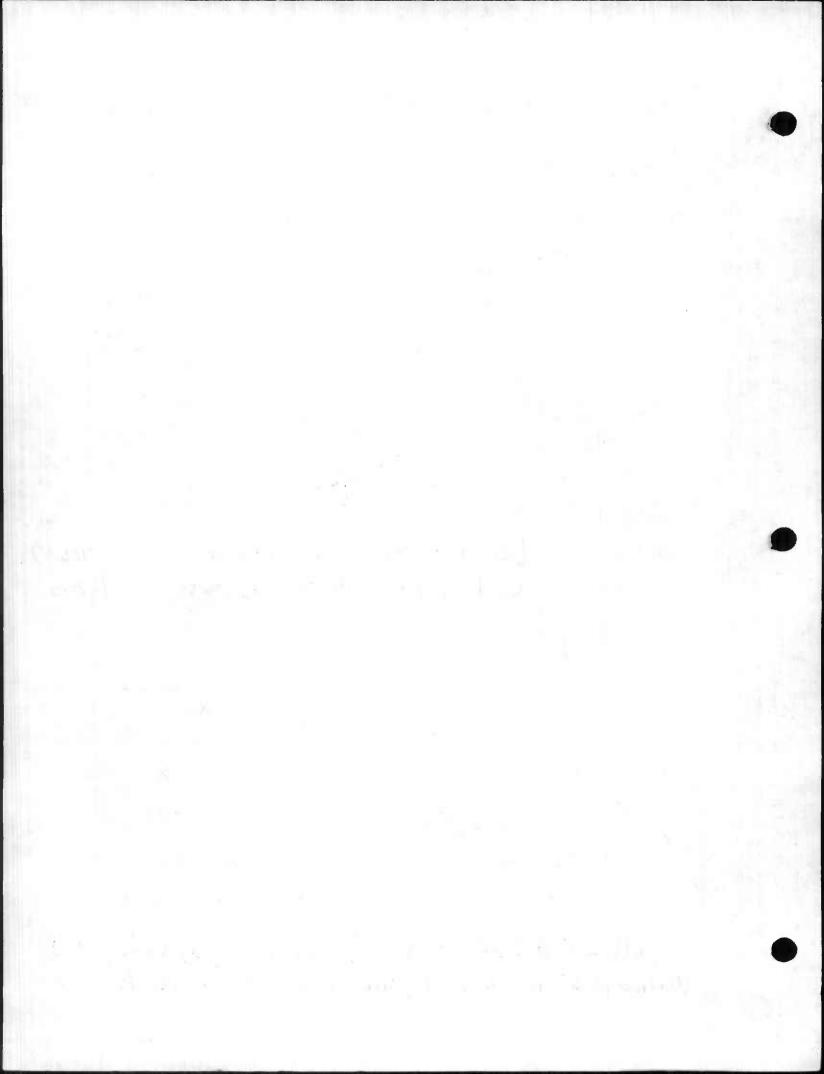
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Miriam

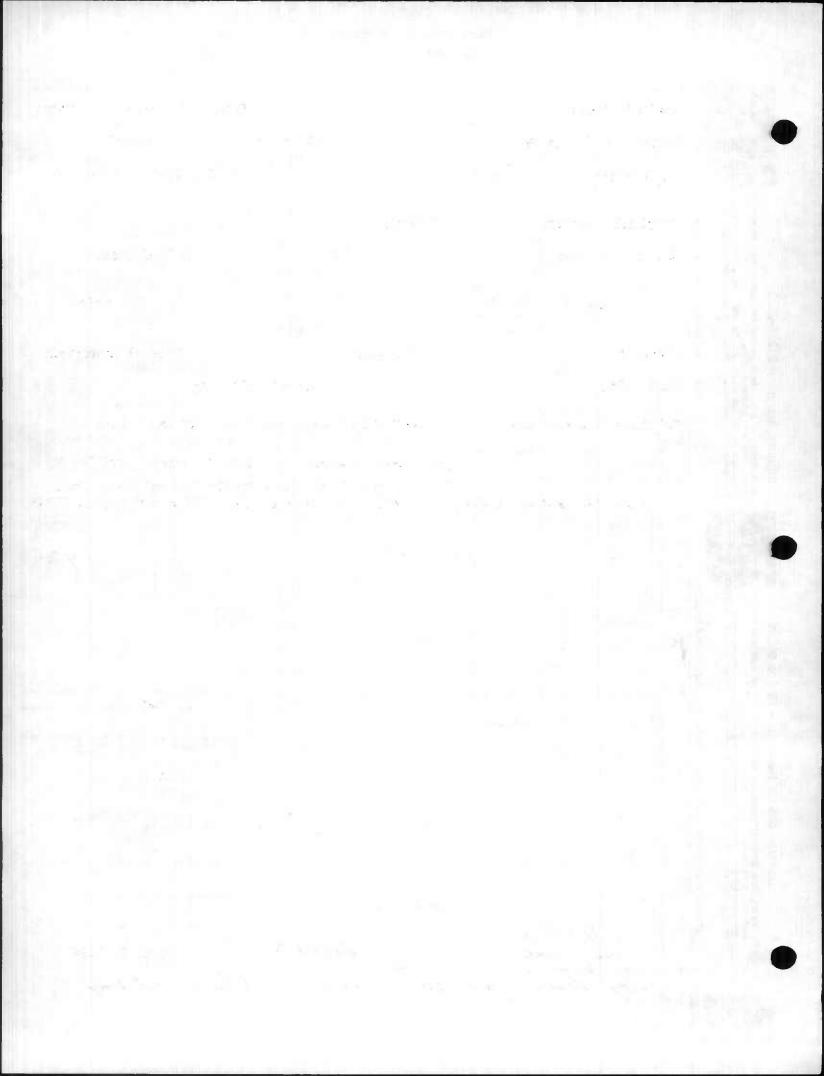


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Neme (First, Middle, Last) Month 12:218m **Physician** UMA 31, 1998 Lomew 0 Augui /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Regional Prince George's Hospital -aure aurel 6. Sex 1 M 2 □ F If Under 24 Hrs. 5. Social Sacurity Number 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days Months Min. Hours 060-26-1826 Director 66 11, 1931 Dec New York Usuel Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow 1 ☐ Yes 2 No Director MD Prince George Laurel 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 9208 Lawnview Lane Нете 23а 20708 USA Funeral death 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Mental Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Nevar Married 2 X Merried Specify: White Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 2 Department of Health and Mentel Hygiene. Important: If item 27 is married other than "na any injury or other traumatic events." United States Elementery/Secondary (0-12) Cottege (1-4or 5+) Years Government. Chemist 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Symeme) Be Anthony Puma Rosaria Pericone 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Dawn Puma /spouse 9208 Lawnview Lane, Laurel, Maryland 20708 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Emmanuel Cemetery 9/4/98 Scaggsville, Maryland 22. Name and Address of Fecility
Donaldson Funeral Home, P.A. 21. Signature of Funeral Service License 313 Talbott Ave. Laurel, Maryland 20707-4389 of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, sist only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Physician/Medical the Due to (or es e consequence of): ettending p deteched Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ Sign S 24a. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to Completed completio n of cause page 2 s 22NO certificate 1 ☐ Yes 2 ☐ No. Division of Vital i or Attending Physician: aftar death. Director: After this certifica director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 1 Neturet 5 Pending 1 Yes 2 No 2 Accident investigation 3 Suicida 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted. 29e. Certifier (Check only one) 29b. Signature and title of certifia 20c. License number 29d. Date signed (Month, Day, Year) 20 ted cause of death (Item 23a) (Type, Print) Prince GeorgeSt 321 32. Registrar's Signature State 1998 Registrar



			State	of Marylar		artment o		and M		giene 9   Reg. No.	3 2	8509
		1. Decedent's Name (First, Mi	ddle, Last)		10/15				2. Date of De Month	ath Day	Year	3. Time of Death
	Physician - /Medical		S						Sept	7 19		9:00am
A	Examiner	4a Facility Name (If not institu		number)					cation of Death			
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	Funeral Director	5. Social Security Number 215–12–5515 Usual Residence of Decedent	6. Sex 1  M 2  M	7. Age (In yrs.	Yrs.	Months Da		Min.	8. Date of Bir (Month, Da Jan 17	y, Year) , 1922	9. Birth	place (Stete or Foreign htry) Lorado
	dand wa	10a. State 10b. Cour	nty	10c. Ci	ty, Town or Lo	ocation					,	10d. Inside City Limits
	Many Many Many Many Many Many Many Many	Maryland Ho	ward		Columb	ia						1 ☐ Yes 2X No
	or 28.	10e. Street and Number				10f. Zip Coo	le			10g. Citizen of	What Cour	ntry?
	23a 23a	6334 Cedar La				210				United		
020	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "batter that be fourthed any july or other traumatic event, the Modical Exactor must be fourthed. To Re-Commissed by Funeral Director	3 ☐ Widowed 4 ☑ Divord	Armed	ecedent Ever in U Forces? es 2 2 No Give or Dates:		Was Decedent If Yes, specify 0 1 ☐ Yes 2 🕱	of Hispanic Original Control of C	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)		ack, White,	can Indian, etc. hite
2-0	72 ho	15. Deced	dent's Education wheat grade complate	ad)	16a. Dece	dent's Usual Oc	cupation	t of worki	ina	16b. Kind of E	Business/In	dustry
2	led within 72 ho lygiena. her than "neturi it, the Wedical	Elamentary/Secondary (0-12		e (1-4or 5+)			ne during most tired)	O WOIN	''9			
2	tygier th	unknown  17. Father's Name (First, Midda	Ho ( oot)		Tecl	hnician	19 Motho	r'e Name	/First Middle	F'edera		verment
Maryland 21215-0020	should be filed and Mentel Hygi marked other umatic event, I	Paul Nolte					Effi	e Ga	llogely	Y		
Mar	12 she h end h end l' is me	19a. Informant's Name/Ralatio								er, City or Town		
	1 and 2 Health em 27 I	Patricia Mass	ейлитесе	20b. I	Place of Dispo	sition (Neme o	f	EE C	Date	aryland 20c. Location		
non	ages ant of t: # lt	1 Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other		om State		metory or other			0.00			
Baltimore,	permit. Pages 1 and 2 Department of Health of Important: if Item 27 is sny Injury or other tra 900.9.	21. Signature of Funeral Servi		Cr	22	wn Ceme	dress of Facility	٧	-9-98			lle, MD
ä	Depar Impor any In	1 54 - 0	CDO	1.300	Ha	arry H.	Witzke	's F		uneral		, Inc. MD 21043
	•	23a. Part1. Enter the disease shock, or haart failure. I	or complications th	at caused he dea	th. Do not ent	ter the mode of	dying, such as	cardiac o	or respiratory a	rrest,	LICY,	Approximate Interval Between
	Physician	snock, or haart failure.	ust only one causa c	on each line.								Onset and Death
d	/Medical	immediate Cause (Final disease or condition		1km	ion ti	9						21/9:-1
	Examiner	resulting In death)	а		or as a consec					15.44		
_	od nine		b	-11								
_60	eath certificate be executed attending physician and for use as the burial-transit clan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury	17.10	Due to (	or as a consec	quenca of):					1	
8760,	siciar b buri	Cause (Disaase or Injury that initiated avants	c	Duo to (	or as a consec	ulanca of):						
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Вох	at the death certifice of by the attending place of the use as the place of the use as the physician/Med		d								i	
	0 0 0	Part II. Other significant cond	littons contributing to	o death but not ras	sulting In the u	inderlying cause	given in Part I.		23b. Dtd	tobacco use co	ontribute t	to the cause of death?
P. O.	ed by the detache								10	Yes 2 No	3 ☐ Pro	obably 4 Unknown
ds,	S								240 11/00		24h W	/ara autopsy tindings
Records,	required hould									an autopsy ormed?	av Cc	vallable prior to empletion of cause
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Vital	certificete rector, pag		ical				ac Place	of Doot	(Check only			☐ Yes 2☐ No
>		examiner? 1 ☐ Yes 2 ☑ No	Hospital:	☐ Inpatient 2☐	ER/Outpatier	nt 3□ DOA	Other:			idence 6 🗆 Ot	ther (Speci	ifv)
100	ding Physical After this funerel display.		28a. Da	ate of Injury fonth, Dey Year)	28b. Time o		njury at Work?	-		how injury occu		**
Ö	Attending in deeth.  Setor: After by the fune liftcation	1 Natural 5 Per	estigation	ional, boy rour,	injury		1 Yes 2 1	No				
Division	tal or Attending P is efter deeth.  al Director: After ted in by the funers Certification:	3 Suicide 6 Cou 4 Homicide dete	ald not be ermined 28a. Pt	ace of Injury - At h	ioma, farm, st	raat, factory, off	ice			Street end Num wn, Stete)	ber or Rur	al Route Number,
	oltal curs el liled i											
	To the Hospital or Attending Phwithin 24 hours efter deeth. To the Funeral Director: After this complataly filled in by the funeral Medical Certification: "	29a. Cartifiar TX Certifiar (Check only 2 Medic	ying Physician: To cat Examiner: On the									
	o the complete			rain at States.		29c. Lic	ense number			29d. Date sign	ed (Month,	Dey, Year)
	- 3 F O	1 4	Land			Di	2117	)		Cont	0	1000
	7	30. Name and address of pers	opywho completed c	ausa of death (Itee	m 23a) (Type,					sept.	. 0,	1. <i>33</i> 0
		/ /	rook	1/01-5 6		loto	ta t		Colon 6	Sept.	216	
	State			2. Registrar's Sign	ature	,				1		
	Registrar	CED 0 9 100	U March	1	7 4	20.11						



State of Maryland / Department of Health and Mental Hygiene (

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Deeth 3. Tima of Death Month **Physician** JOSEPH ANTHONY PETROSILLO August 23, 1998 8:10 am /Medical 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8070 Savage - Guilford Road Jessup Howard | H Under 1 Yaar | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 15 1917 5. Social Sacurity Number Birthplece (State or Foreign Country)
 New York 7. Aga (In yrs. last birthday) **Funeral** 1♥M 2□F Months 127-10-6597 Yrs. Director 81 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahow the Medical Examiner must be notified at Director 1 Yas 2 No Maryland Howard Jessup the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8070 Savage - Guilford Road 20794 USA Funeral 12. Was Decedent Evar in U.S. Armed Forces? 1 ∰Xas 2 □ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12)
Grade 12 College (1-4or 5+) Foreman Silk Manufacturing other permit. Peges 1 and 2 should be fits
Department of Heelth and Mantel Hy
Important: If Nem Z7 Is marked oths
any Injury or other traument 17. Fether's Neme (First, Middla, Last) 18. Mother's Nema (First, Middle, Maiden Sumama) Be Joseph A. Petrosillo Agata Spilotro 19e. Intormant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 8070 Savage - Guilford Rd. Jessup, Maryland 20794 Anita Nicotra daughter 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Augata8, 1 ☐ Burial 2 ☐ Cramation 3 💆 Removal from State 1998 4 ☐ Donetion 5 ☐ Other (Specify) Calverton National Cem. Calverton, New York 21. Signature of Funerel Service Licenses 22. Nema end Addrass of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the diseasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician Immediate Cause (Finet disaese or condition resulting In deeth) /Medical Malignant Cachexia Examiner Dua to (or as e consequence of): Examiner Cancer of lung April 10,98 physician and s the bunal-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Dua to (or as a consequance of): Sarcoma right pelvic region Box 68760. June 17, 98 Physician/Medical Due to (or as a consequence of) ettending | Carcinoma of prostate P.O. ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records. þ Completed 24b. Were autopsy tindings avelleble prior to 24a. Wes an autopsy performed? complation of cause of death? page 2 s hes 1 ☐ Yes 2XXXIII 1 ☐ Yes 2 XXVo certificate Division of Vital tal or Attending Physician: The selfer death.

at Director: After this certificate in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 10 Hospitel: Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 1 ☐ Yes 2 XX 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Mennar of Deeth 28c. Injury at Work? 28b. Time of 28d. Dascribe how injury occurred Certification: Netural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not ba 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 ☐ Homlcide Hospital 24 hours edical 29a. Certifier 15 Certifying Phyalctan: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to tha cause(s) and menner stated. To the Hosp within 24 hou To the Fune completely fi (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) m 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Pratima Bose, M.D. Suite 803 - 301 St. Paul Place Baltimore, Maryland 31. Data filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 5 1998 Denewa

Registrar



	A Deceded Nove				Cer	tificate o	f Death		g. No.		
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iner	The state of the s		ive street and number				4b. City, Town, or L	ocation of Death	4c. Count	y of Deeth	
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l r	5. Social Security N 577-26-		Sax 7 1 □ M 2 🗓 F		. last birthday)_ Yrs.	Months Dey		8. Dete of Birth (Month, Dey, Year) 9. Birthpiece (State of Country)			
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to	MARYLAND	PRINCE	GEORGE'S	1	RIVERDA	LE					1 ☐ Yes 2 🔀
Directo	10e. Straat and Nu	mbar				10f. Zip Coda		10	g. Citizan of	What Cou	ntry?
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To B	HENRY MO	OORE					MARGARE	T EVANS			
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	20e. Method of Disp		☐Removei from Stel		Plece of Dispos	ition (Name of atory or other p			Oc. Location		
		5 Other (Spec			RT LINC	OLN CRE	MATORY	9/3/98 E	BRENTW	00D.	MARYLAND
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State Registrar 31. Dete filed (Month, Day, Year)
SEP 0 3 1998

32 Registrer's Signature

B. Spark

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The lew requires that the death certificate be executed

RUDY, MARION CATHERINE

Baltimore, Maryland 21215-0020

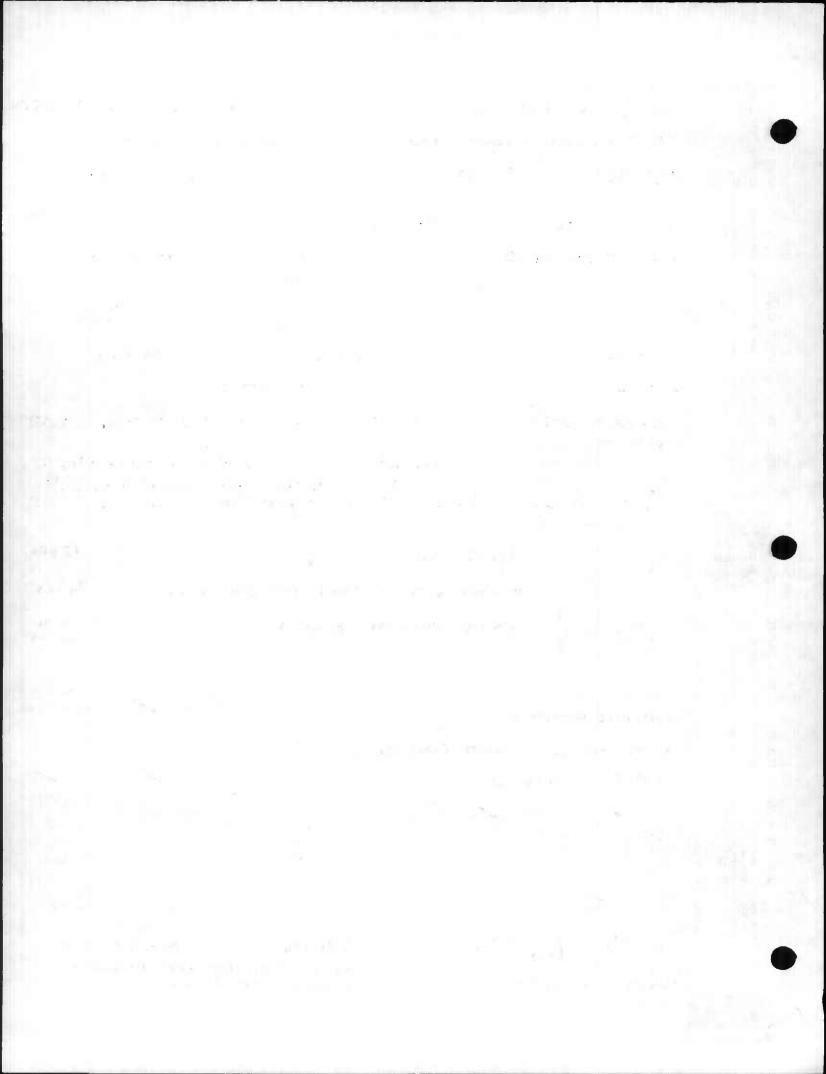
### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

		1. Decedent's Neme (First, Middle	a, Last)					2. Date of De		Vest	3. Time of Deeth
Physici Medic/		GEORGE W	ASHINGTON	ROOP				Month Septemb	Day	Yeer 998	19=28 1
/weak Examir		4e. Fecility Name (If not institution					4b. City, Town, or I				10 20 1
		3411 James Run	Road				Aber	deen	Н	arfor	đ
uneral		5. Social Security Number		7. Age (In yrs	. last birthdey)	If Under 1 Year Months Days	If Under 24 Hrs.				ece (Stete or Foreig
rector		220-22-8915	1 <b>∑</b> M 2□ F	68	Yrs.	Months Days	Hours Min.		1930	Mary.	
		Usuel Residence of Decedent  10a. State 10b. County		100.0	in Town out a						
N N	2	Maryland Harfo	ord		ity, Town or Lo Aberdee					100	d. Inside City Limit: 1 ☐ Yes 2 ☑ No
No.	Director	-	, L Q		MOCIACO						
el', or itema 23a or 28a-f show Examiner must be notified at	급	10e. Street and Number 3411 James R	nn Poad			10f. Zip Code 21(	001		10g. Citizen of \	Whet Countr	ry?
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edical Exam	by F	3 □ Widowed 4 ☑ Divorcad	If Yes, Give	9	1	☐ Yes 2 No	Specify:		Specify	whi	te
ofical E	8	15. Decedent	's Education		16a. Deced	lent's Usuai Occu	pation		16b. Kind of B	usiness/Indu	ustry
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Verit	Be Completed	17. Father's Name (First, Middle, L					18. Mother's Nan				
a c	To	Rufus Roosevel	t Roop				Virgie	Virgin	ia Bisho	p	
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em 27 is marked other than ther treumatic event, the M		Linda M. Hope/	'Daughter		3413	James I	Run Road,	Aberdee	en, MD	21001	
Important: If item 27 is n any injury or other treun once.		20a. Method of Disposition	0 CD		Piaca of Dispos cemetery, cren	sition (Name of netory or other pla	aca)	Date	20c. Location -	City or Tow	m, State
ury o		1  Burial 2  Cremation 4  Donation 5  Other (Sp		iare		Baptis		/5/98	Bel Air	r, Mar	yland
y In		21. Signature of Funeral Servica L	icansee / /			Name and Addre					
E 2 8		1 Steller	Murila				McComas				
		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that ca	used the dee	th. Do not ente	er the mode of dy	sbury Roa	or respiretory e	rrest.	210	Approximate Intervei Between
sician		shock, or neart failure. List of	only one mause on ea	ich line.							
_										į S	Onset end Death
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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Certific	cate of Deat		Reg. No.	20	513
ı	Physician	1. Decedent's Nema (First, Middle, Last)  RUTH C. RUSS ELL		2. Dete of D Month	Dey	Yeer	3. Tima of Death
	/Medical	de Facility Name (Mast institution aire street and number)	4b. City.	Town, or Location of Dee		of Death	7:451
	Examiner	HOWARD COUNTY GRNGRAL HUSPITAL		LUMBIA	Itom		
	Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Mon 20 F 83 Yrs.	ndar 1 Yeer   If Und	er 24 Hrs. 8. Data of B Min. (Month, L	irth ley, Year) 0, 1915	9. Birthple Count	aca (Stata or Foreign y)
	pud *	Usuel Residence of Decedant  10a, Stata 10b. County 10c. City, Town or Location				10	d. Insida City Limits
	Menyl	Maryland Howard Columbia					1□Yas 2☑No
	or 28e-f s	10e. Street end Number 10	f. Zip Code		10g. Citizen of V	Vhat Count	ry?
	th with		21045		Unite	ed Sta	ates
21215-0020	72 hours efter deeth with the Meryland netural; or items 23s or 28s-f show or all Examiner must be notified.	3 Notice at 1 Yes, Giva 1 Yes or Detes:	Decedent of Hispenic Specify Cuben, Mexic es 2년 No Speci	Origin? (Specify Yes or N can, Puerto Rican, atc.) ify:	lo- 14. Race Bied Specify	e - Amarica ek, White, e White	tc.
5-0	in 72 hours in actural; in actural;	15. Decedant's Education 16e. Decedant's (Specify only highest grade completed) (Give kind of Give kind of Gi	Usuel Occupetion of work done during m of use retired)	ost of working	16b. Kind of Bu	usinass/Ind	ustry
121		Elementery/Secondary (0-12) Collage (1-4or 5+) Unknown Hom	ot use retired) nemaker		0.50	TTomo	
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	Tr.			ves Court E		pris .	
Baltimore,	Pages nent of int: if it iry or o	20e. Method of Disposition  1 🖾 Burial 2 □ Cremation 3 □ Ramoval from State  4 □ Donetion 5 □ Other (Specify)  20b. Place of Disposition camatery, cremetory  Crest Lawn	(Neme of or other place)	Data 8-25-98	20c. Location -		vn, Stete
Balt	pemit. Pag Department Important: i eny injury o phos.	21. Signeture of Funerel Service Licensaa 22. Nam Harri	y H. Witzl	ke's Family Thia Pike El	Funeral	Home,	Inc. MD 21043
	Physician	23a. Part1. Entar the disease, or complications that caused the death. Do not anter the shock, or haert failure. List only one cause on each line.					Approximete Interval Batwaan Onset and Daeth
4	/Medical Examiner	Immediate Cause (Finel disease or condition					12 HRS
н	HI KAR	resulting in deeth)  Due to (or es e consequence	0				
1	n end iel-trensit	b. INCARCERATESO		HACEAL 1	normia		29 thes
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Box 68	attending phi for use es th	resulting in death) Last					
	at the death certing of by the attending leteched for use e Physician/M	Pert II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Pa	nt I. 23b. Di	d tobacco usa co	ntribute to	the cause of death?
P.0	at the de lby the steched	GASTRIC BEZONE		10	Yes 2016	3 ☐ Prob	ably 4 Unknown
Ś	bed by					T	
of Vital Record	The law requires that the death cert sate has been signed by the attending page 2 should be deteched for use Completed by Physician/M	CONCESTIVE GRANT FAILURE		24e. We	es en eutopsy formed?	ave	re eutopsy findings illabla prior to npletion of cause leeth?
E B	The page	GASTRIC VOLVUUS		10	Yes 2 No	1□	Yes 2010
Vita	certificate rector, pag	25. Wes case refarred to medical axeminar?	Other	ece of Death (Check only			
of	Physic this c			Nursing Home 5 ☐ Re	sidence 6 Oth e how injury occur		)
	ding h. After fune	27, Mannar of Daeth 28e. Data of Injury (Month, Day Year) 28b. Time of Injury And Injury M	28c. Injury et Work? 1 \sum Yes 2		o non anjuny coods	.00	
Division	tal or Attanding P rs efter deeth. al Director: After led in by the funers Certification:	Suicide  3 Suicide  4 Homicide  6 Could not be determined  28e. Place of Injury - At home, ferm, street, fabuilding, etc. (Specify)	actory, office		(Street end Numb own, Stete)	ber or Rure	Route Number,
	To the Hospital or Attanding Physician: within 24 hours efter death. To the Funeral Director: After this certifior completely filled in by the funeral director. Medical Certification: To Be (						
	No the	29b. Signature and titla of certifier	29c. Licansa numbe	ər	29d. Data signe	d (Month, I	Dey, Year)
		1977	D 3697	4	AUG :	22,1	995
		30. Name end eddrass of person who completed ceuse of death (Item 23e) (Type, Print)  DAVID O NYANTON  31. Date filed (Month, Day, Year)  AUG 2 4 1998  32. Registrer's Signeture	10724 L Colume A	MD 21	XENT PA	nkw	my
	State	. 31. Date filed (Month, Day, Year) 32. Registrer's Signeture	1				
	Registrar	AUG 2 4 1998 Agree 19.	parkel				



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26 199 4b. City, Town, or Location of Deeth 00 AWRENCE 4a Fecility Name (If not institution, give street and number) 5. Social Security Number 6. S If Under 1 Year Months Days (7. Age (In yrs. last birthday) nton If Under 24 Hrs. 9. Birthplece (State or Epreign Country) 6. Sax 8. Dete of Birth (Month, Day, Year) Min. Hours 15 M 2□ F 2 20 POST WASH. **Usual Residence of Decedent** 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No AUGOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Court KAPLAN 20185 USTIUU STATES 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ₩ Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 1 rayate JANITOF 12 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) HELEN Smith UNKNOWN 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 🗘 🗘 🕻 🐒 735 24mille KAPIAN wornsol hondour illd 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location · City or Town, State 1 Qurial 2 Cremation 3 Removel from State 9-2-98 Clinton 4 Donation 5 Qther (Specify)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

735

Director

Funerai

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Completed

**Funeral** 

Director

the Menyland

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permit. Peges 1 and 2 should be filed within 72 hours effer c. Department of Health and Mental Hyglene. Important: if Nem 27 is marked other than "naturel", or hem any Injury or other treumatic event, the second of the permit of the marked other than "naturel", or hemotop.

physicien end s the burlei-trensit

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. þ Completed

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 PNatural

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certified

3 ☐ Suicide

29a. Certifier

Immediate Cause (Final disease or condition resulting in death)

21. Signature of Funeral Service Licensee

re. List only

tations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, is cause on each line. ary thruce Condiac Due to (or as a consequence of):

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Mi.

28b. Time of Injury

Var sal aceds

1601

Due to (or es a consequence of):

Approximete Intervel Between Onset end Deeth

Nov.

fue, b.E. WASH. D.Q

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy tindings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed?

1 Yes 2 No 1 Yes 2 No

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 28c. tnjury at Work? 1 Yes 2 No

22 Name and Address of Facility STERLING functual

Kenilwowth

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30/ Name and address of person who completed cause of death (frem 23a) (Type, Print)

Hospital:

5 Pending investigation

6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

1328 Southern Ave # 202 Washington 31. Date filed (Month, Day, Year) 32. Registrar's Signeture

State Registrar

8

this

After

Certification: To

edicai

AUG 3 1 1998

Sparks

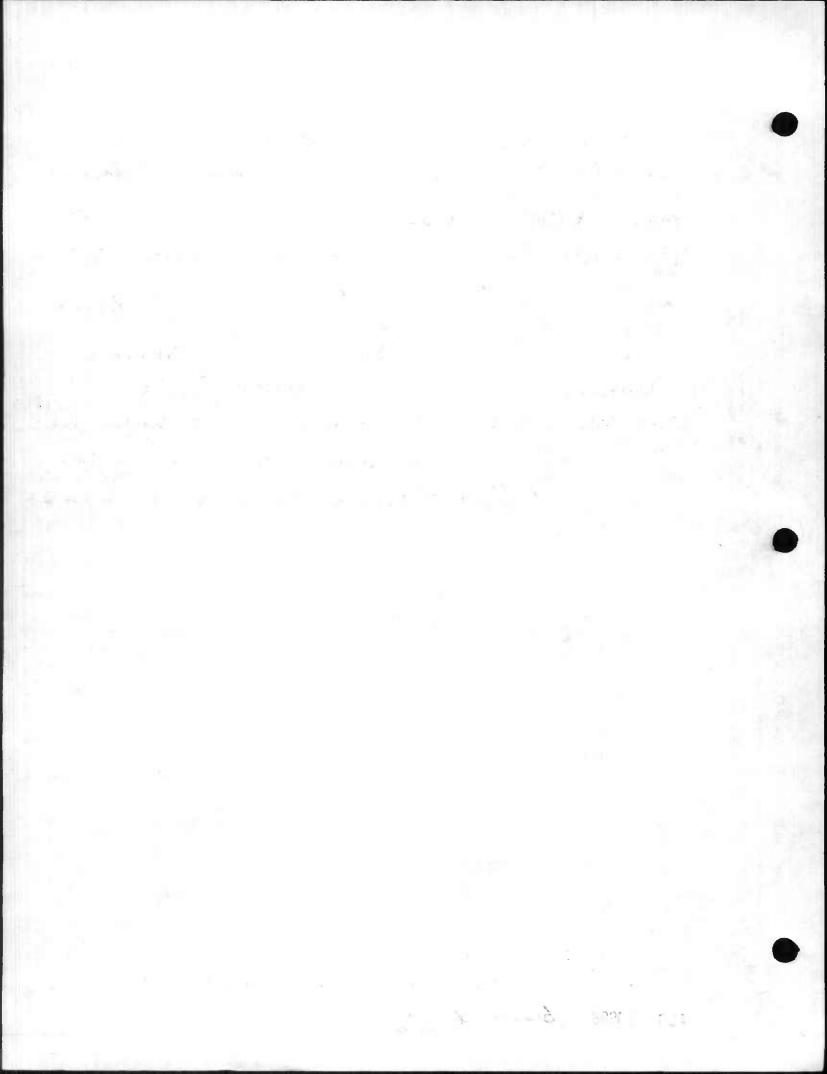
**DHMH 16 Rev 6/95** 

Box 68760, P.O. Records,

The lew requires that the deeth certificate be executed or Attending Physician:

Division of Vitai

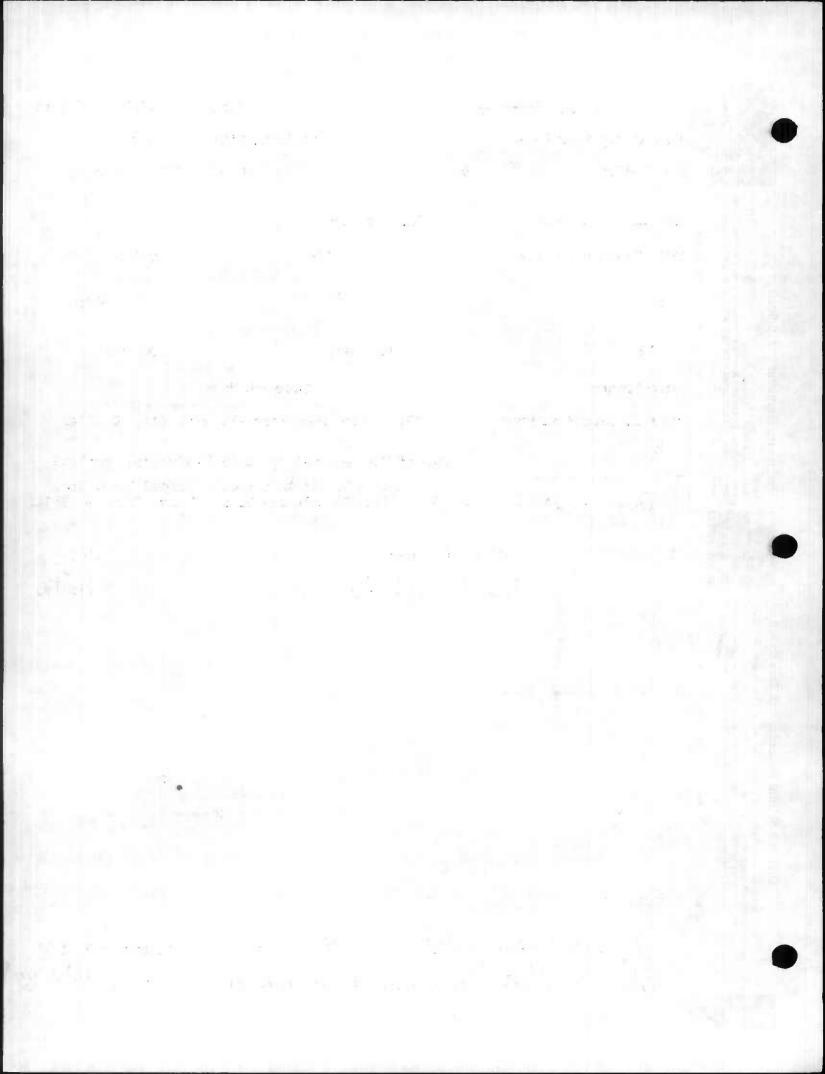
To the Hospital or Attending within 24 hours effer death.
To the Funeral Director; Afte completely filled in by the fun



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al		5. Sociel Security Number	6. Se	эх		yrs. lest birthdey)	If Unde	r 1 Year	If Under 24 H	rs. 8. Date of Bi	rth		lece (Stete or Fore
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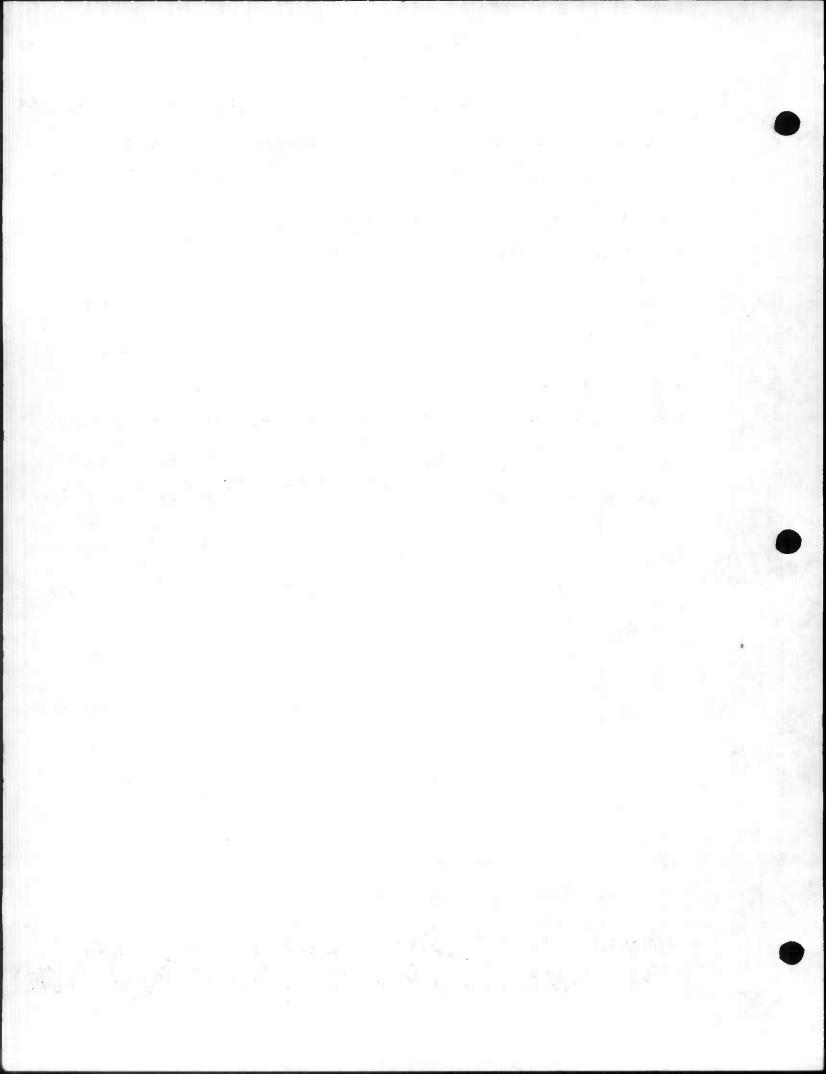
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tel Hygiene.  d other than "natural", or items 23a or 28a-1 show event, the Medical Examiner must be notified at Be Completed by Funeral Director	Usuel Residence of Decedent  10a. Stete 10b. Count		100 City	Town or Loc	nation					14	Od. Inside City Limits
I Health and Mentel Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Exampler must be northed at other traumatic event, the Medical Exampler must be northed at To Be Completed by Funeral Director										1	1 ☐ Yes 2 No
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2	ucua	9,000	A		101	u i i	)		Septe	mper	8, 1998
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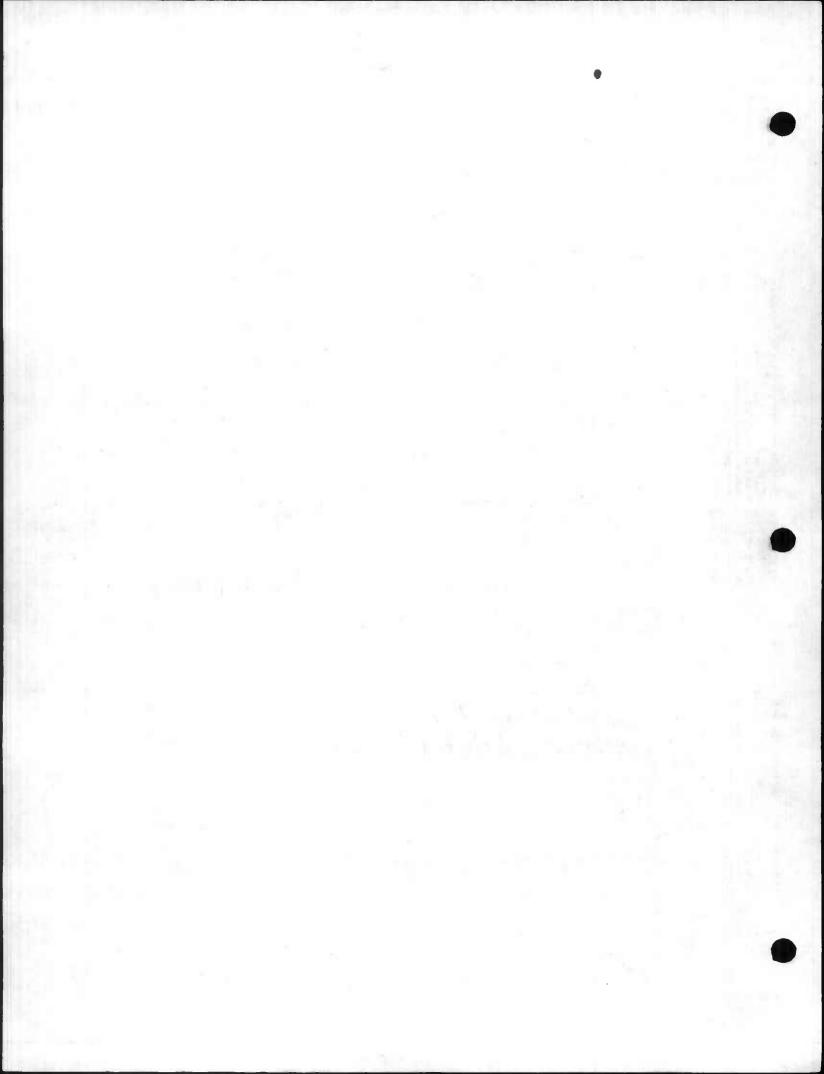
State of Maryland / Department of Health and Mental Hygiene

-					Certifica		Death		Reg. No.	Mo	1160	
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should be nd Mentel marked o	2	David Allen Leisher Laura F						lizabeth Shade				
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rtant		4 Donetion 5 Other (Special		Metro	Cremato	ory		8-25-98	Catons	sville	e, MD	
Deficient Page Department of Important: if any injury or once.		21. Signature of Funeral Servica Licar	mo-voi	ande	4112	old c	ss of Facility litzke's l clumbia l	Pike Ell	icott (	Home,	Inc. MD 21043	
Physician /Medical Examiner	16	23e. Pert1. Enter the disease, or complications that caused tife death. Do not enter the mode of dylng, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death  Immediate Ceuse (Final disease or condition resulting in death)  Due to (or es e consequence of):  Due to (or es e consequence of):  COMANY AMERY DISEASE  Approximate Interval Between Onset and Death  Pory 5  Heart Sequence of Sequence										
LAMINICI		resulting in death)	^	Due to (or es e	consequence of	):	) ,				1	
led nsit	Examiner	Commany Artery Visease									tears	
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eath cert ettending	M		d				· · · · · · · · · · · · · · · · · · ·					
death death	sicia	Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I.  HYPPENSION						23b. Did tobacco use contribute to the cause of death?				
d b	by Physician/I								1 Yes 2 No 3 Probably 4 Unknown			
aw requi	Completed	.,						24a. Wes e	en eutopsy med?	eva	re eutopsy findings ilable prior to opietion of cause eath?	
The is	S							1□ Y	es 21 No	1 🗆	Yes 2□ No	
ysician: The	Be	25. Was case referred to medical examiner?  26. Plece of Death (Check only one)										
Ing After fune	ition: To	1 Yes 25 No  27. Menner of Death 1 Maturel 5 Pending 2 Accident Investigation	Hospital: 1 Appatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify)  28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury M 1 Yes 2 No							)		
or Air	Certification:	3 Suicide 6 Could not be							28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To the Hospital within 24 hours e To the Funeral C	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as steted.  Check only one)  Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.										
To the To the Comp	M	29b. Signature end title of certifier	16	A	10 25	c. Licenso	9 number 9 4/27	/ 2	9d. Dete signe	d (Month, C	1998	
4		30, Neme and address of person with completed cause of death (Item 23e) (Type, Print)  MICHAEL SI INPUT MON. M.T. HOWAY COLUMN (SPUPIN) HIS RITHER SOLVEN										
Sta Registr		31. Date filed (Month, Dey, Year)	32. Registre	n's Signature	10000	1	VILTY CI	-IUU!	יןנייוי		21044	



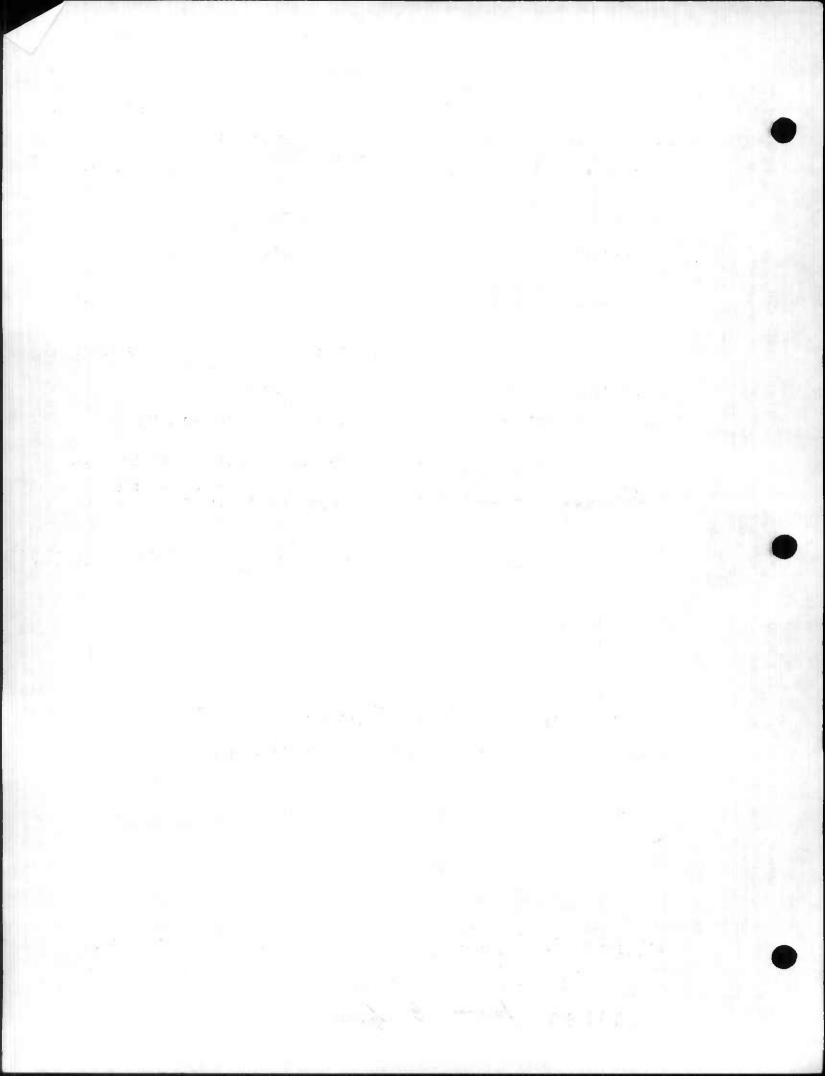
State of Maryland / Department of Health and Mental Hygiene

					Otate C	n iviai yiai		ertificate of		ivicinality	Reg. No.	0	518		
	Physicia	n								2. Date of Do Month	Day	Year	3. Time of Death		
	/Medica	_	Gilbert I. Sherman						Augus	_	1998	7:20 PM			
	Examine	er	Laurel Regional Hospital  4b. City, Town, or Lo Laurel Regional Hospital  Laurel Regional Hospital							ure/	1 0				
be filed within 72 hours after deeth with the Meryland (at Hyglane).  Ital Hyglane.  d other than "natural", or items 23a or 28-4 show and other than "natural".	Funeral Director		5. Social Security No. 216–28–74	-7400 MOXM 2□F 74 Yrs. Months Deys Hours Min.					n. (Month, D	8. Date of Birth (Month, Day, Year) Nov 30, 1923  9. Birthplace (State or Foreign Country) Virginia					
	land land		Usual Residence of Decedent  10e. Stete 10b. County 10c. City, Town or Location							10d. Inside City Limi					
	a-f sh	io	Md. Howard J				Jessup				1 ☐ Yes 2 🕅 No				
	or 28	Director	10e. Street and Number					10f. Zip Code		10g. Citizen of	What Countr	y?			
	eth w	la l	8235 Glen	Court				2079		USA					
	or its	Be Completed by Fur	11. Merital Status  1 Never Marrie  3 Widowed		Armed Fo	2 □ No	J,S. 13	. Was Decedent of I If Yes, specify Cub	dispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	Special	ce - America ick, White, et by: Whi	c.		
	72 ho		(Speci	ucation de completed)	completed) /		a. Decedent's Usual Occupation (Give kind of work dona during most of working			16b. Kind of E	lusiness/Indu	estry			
	within the		Elementary/Secon		College (1-4or 5+)		'life. DO NOT use retired) Truck Driver			II S	S. Dept of Agric.				
	Hygia ther ther ent, m		Grade 7  17. Father's Nama (	First, Middle, Last)		TEUCK DETV			18. Mother's N	ame (First, Middle	le, Maiden Sumama)				
	id be ental ked o									Shermar					
ary			19a. Informant's Na		ype, Print)		19b. Mai	ling Address (Street			ral Route Number, City or Town, State, Zip Code)				
	1 and 2 Health e em 27 le		Mary Alic		n			Glen Cou	rt Jess	sup, Mary	ryland 20794				
imore	Pa anti-			osition Cremation 3 Di 5 Dother (Specify			cemetery, cr	osition (Name of ematory or other pla Cemetery	ce)	Date 9/3/98	20c. Location Savage	-			
Ball	pemit. Pag Department Important: i any Injury o		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Donaldson Funeral Home, P.A.  313 Talbott Avenue Laurel, Maryland 20707												
N			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.												
	Physician /Medical Examiner		Immediate Cause (Final disease or condition a Cordial WUST 48 hours												
	_	e e	resulting in death)  Due to (or as a consequence of):  Condition of the consequence of th												
	d d ensit	Examiner	Companies the list con	editions C	b. Cur	Due to (	OCCUPATION OF THE PROPERTY OF	ad A L LA C	1016	They or	correct	701-02	10 years		
0,		_	Cause (Disease or Injury that initiated events  Due to (or es e consequence of):								m cereby Vasulor				
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Box	death certifi e attending ed for use as	L San	0												
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0.	signed b	00	Dialnos Memor ryn							-	1 Yes 2 No 3 Probably 4 Unknown				
of Vital Records,	The law requiras that the sta has been signed by the page 2 should be detached.		Hyper	tennor	7, 8	ilate	ed C	nrdon	yoyath	24a. Wa	s an autopsy lormed?	evai	e autopsy findings lable prior to pletion of cause eath?		
R	The la		U							10	Yes 2 No	10	Yes 2 No		
Vita			25. Was case raferre examiner?		Hospital:			Ott		eath (Check only	one)				
	this raid	0	1 Yes 2 Nanner of Death	NO	26a. Date		28b. Time	ent 3LI DOA	4 LI Nursing	Home 5 Res	idence 6 Ot how injury occu				
E 2	Attending For death.  Sector: After by the funeral	LIOI	1 Natural 2 Accident	5 Pending investigation	(Month, Day Year) Injury Work?										
Division	i or Atter after dea i Director d in by the	Certification:	3 ☐ Suicide 4 ☐ Homicida	6 Could not be determined	289. Place	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					8f. Location (Street and Number or Rural Route Number, City or Town, State)				
		edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated.												
	Withir To th comp		29b. Signature and title of certifier 29c. License nur							umber 29d. Date signed (Month, Day, Year)					
	10 .		1 menule D13671						8.30.38						
	Ivet		30. Nama and addra	SS OF PERSON WITH C	WAL	sa of death (Item	n 23a) (Type	20 La	wel	PARK 8	y Kan	irel p	10 22707.		
	State Registra	=	31. Date filed (Month	REP (1 1 1	32. F	Registrar's Signi	ature	4 1	. ,						



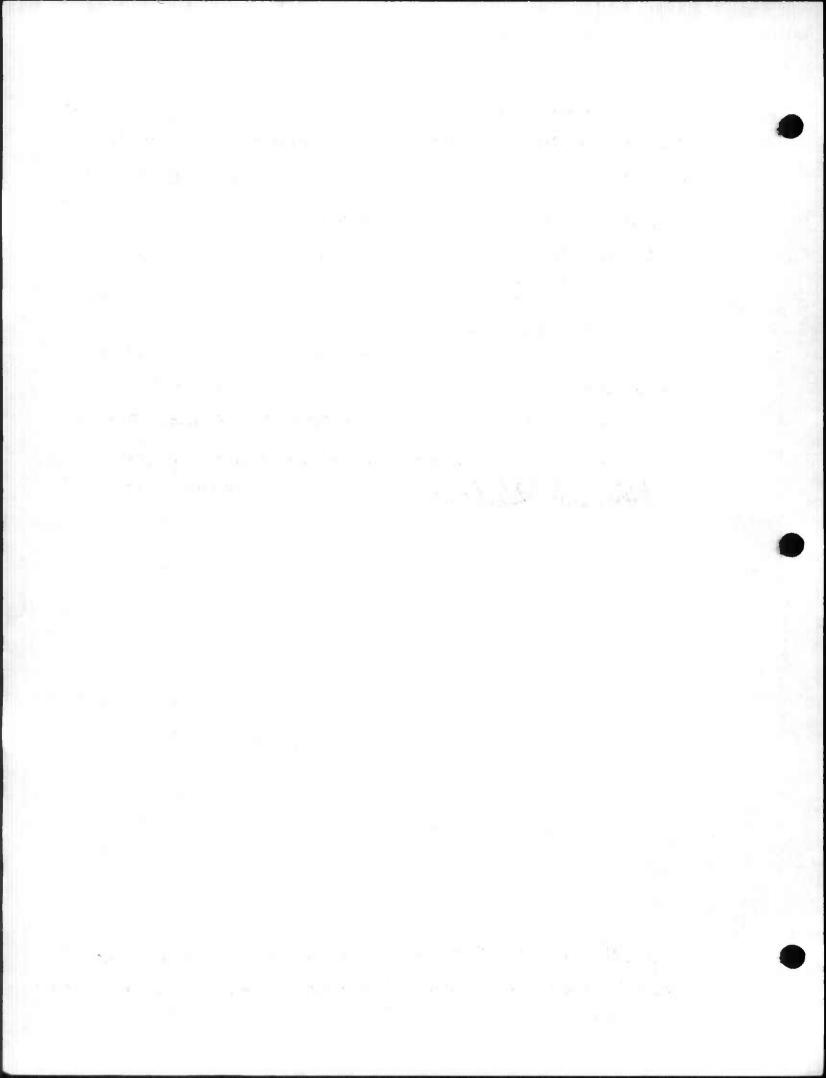
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Physician /Medical		GEORGE	HERB	ERT S	HAFFI	ER		,					98	1117
Examiner	4a Fa	cility Nama (If not instituti									tion of Death	4c. County		
		RROLL COUNTY		RAL HO	SPITA	L				MINS'			RROLL	
Funeral Director		ial Sacurity Number 9–18–2167	6. Sex	2□ F 7.	Age (In yrs. 74	last birthday) Yrs.	Months Months	Days	If Undar 2	4 Hrs. 8 Min.	Data of Birth (Month, Day CT 20	, 1923	9. Birthplac County MARYI	ce (Stata or For AND
2		Rasidence of Decedant			40- 0	. T							140-	t to alde Other Lie
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ifer death with the Meryland r flams 23s or 28s-f show doer must be notified at Funeral Director	10e. S	treet and Number 527 TRENTON	ROAD				10f. Zip	p Coda	211	.55		0g. Citizen of	What Country USA	y?
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State of Maryland / Department of Health and Mental Hygiene

P. PATONIA	ian	1. Decedent's Name (First, Middle, Las	st)				2. Data of De Month		Year 3. Time o		
Physici /Medi		Mary Elizabeth					August		9:06		
Exami	ner	4a. Facility Nama (If not institution, give Carroll County G	A SALICE TO SALICE	enital		4b. City, Town, or Westmin	Location of Daath		of Death ro11		
- uneral Director	0	Social Security Number 6. S		e (In yrs. lest bir	thday) If Under 1 Yaar Months Deys	If Under 24 Hr	s. 8. Dete of Birt		9. Birthpleca (State Country) Virginia		
		Usual Residence of Decedent					[IIPI . 22	, 1720	V11 511110		
Show Market	-	10a. Stete   10b. County     Marvland   Carro	11	10c. City, Tow	norLocation New Winds	- 20			10d. Inside 0		
288-1	ecto	Maryland Carro	11		10f. Zip Code	01		10g. Citizen of W			
23a or	Funeral Director	2845 Carlisle Dr				21776		U.S.	Α.		
ribere. The Medical Examiner must be notified at the Medical Examiner must be notified at		11. Marital Stetus 1 ☐ Nevar Marriad 2 ☐ Married 3 ঐ Wildowed 4 ☐ Divorcad	12. Wes Decedant E Armed Forces? 1 ☐ Yas 2 ☒ N It Yes, Give Yeer or Dates:		13. Wes Decedent of If Yes, specify Cub		Specify Yes or No rto Rican, atc.)	Specify:	- American Indien, k, Whita, atc. White		
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d other i		17. Fether's Neme (First, Middle, Last)			nousew		eme (First, Middle,				
marked other	To Be	Horace Jones					Sadie Edv		7		
	-	19e. Informant's Name/Reletionship (7	ype, Print)	19b	. Meiling Address (Stree	t end Number or F	Rural Route Numbe	er, City or Town, S	Stete, Zip Code)		
25		Debra Moorehead/	daughter	10	075 Adams V	lillett R	ld. Nan	jemoy, M	1D 20662		
5 = 5		20e. Method of Disposition 1 ☐ Burlal 2 ②Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemeter	Disposition (Name of y, cremetory or other pla 11 Crematio		Dete 8/31/98		city or Town, State		
Important: I any injury o		21. Signature of Fugeral Service Liceo	J. Want	blew	22. Neme end Addr		tzler Fu	neral Ho	ome 21776		
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State of Maryland / Department of Health and Mental Hygiene

					Cer	tificate	e of	Death		Reg. No.	9 6	0021
Physici	an	1. Decedant's Name (First, Middla, La	st)						2. Data of Da Month	ath Dey	Year	3. Time of Death
/Medi		MILDRED ELAIN	ETHORNE						Sept.	1, 199		12:50 a.m.
Examir		4a. Facility Neme (If not institution, giv	a street and number)					4b. City, Town, o	r Location of Deat	h 4c. Count	y of Death	
		HOLY CROSS HOS	PITAL					Silver	Spring	Mo	ntgom	nery
Funeral Director		5. Social Sacurity Number  578-64-3072  Usual Rasidance of Decedant	ex 7.Ag □M 2[x]F	e (In yrs. las	st birthday). Yrs.	if Undar Months	1 Yaar Days	If Under 24 Hr Hours Mir	. (Month, De	th ly, Year) 7, 1937	9. Birtho Cour Washi	olaca (Stata or Foreign itry)
and and		10a. State 10b. County		10c. City,	Town or Lo	cation					1	Od. Insida City Limits
Meny	to	Manual Prince	George's	Cap	ital :	Heigh	t.s					1X Yes 2 □ No
28s	Director	Maryland Prince ( 10e. Street and Number		J		10f. Zip				10g. Citizen of	What Cour	ntry?
3a o		6510 Weston Ave	0110				207	43		Unite		
n 72 hours after deeth with the Meryland "natural", or Items 23s or 28s-f show so cal Examinet must be notified at	by Funerai	11. Maritei Stetus  1 Naver Marriad 2 Married  3 Widowed 4 Divorced	12. Was Decedant Armed Forcas? 1 ☐ Yas 2 ☑ If Yas, Give Yaar or Datas:			Was Deced f Yas, spec	lant of I		Specify Yes or No rto Rican, atc.)	14. Re Ble Speci	ce - Americ eck, Whita, fy:	
2 hou		15. Decedant's Ed			16a. Deced	fant's Usua	i Occu	pation		16b, Kind of E	Businass/Inc	
d within 72 ho plena. r than "natur the Med cell	Completed	(Specify only highest gra			(Giva I	kind of wor OO NOT us	k done a retire	during most of word)	orking			,
d within glena. r than "	E	1 1	College (1-4or 5	)+)	Licens	sed Day	7 Can	re Provide	r	Se1f	Emplo	oved
be filed ntal Hygle of other event, ii	Bec	17. Fathar's Nama (First, Middla, Last)							ame (First, Middla			
0 0 0 0	TOE	Arthur Green						Glad	ys Field:	5		
S D E E		19a. Informant's Name/Ralationship (	Type, Print)		19b. Mailin	g Addrass	(Stree	·	Rural Routa Numb		, Stata, Zip	Code)
に高ると		Denitra Hawkins	- Daughte	r 7	7705 K	Cloust	tad	Road, Fo	ort Wash	ington,	MD	20744
		20a. Mathod of Disposition			ca of Dispos netary, cram	sition (Nam	ne of	ne)	Deta	20c. Location	- City or To	own, State
permit. Peges Department of I Important: If Its any injury or o		1 ☑ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification )							9/4/98	Landoua	~ Mo	ruland
artm ortar		21. Signatura of Funaral Sarvice Licen		пап	mony Me			IK ass of Facility	3/4/30	Landove	I, Ma	Tyland
Dep imp		DO TO	11 1	-	ST	TEWAR:	r Fu	JNERAL HO	OME, Inc			
		23a antt1. Enter the disaase, or compock, or haart failure. List only	Kewari		40	001 Be	enn:	ing Road	, N.E., W.	ashingt	on, D	. C. 20019 Approximata
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death ne atter ed for u	Physician	Part II. Other significant conditions or	ontributing to daath bu	ut not rasulti	ng in tha un	ndarlying ce	eusa gi	van in Part I.	23b. Did	tobacco use co	ontribute to	the cause of death?
that tha	Å.								10	Yes 2 No	3 Prof	bably 4%] Unknown
gned be de	by	Short Bowel Synd	rome, Chro	nic								
e law requires that tha death ce has been signed by the attendi ge 2 should be detached for use	Completed	Renal Insufficie	ncy, Secon	ndary						an autopsy ormed?	av	ara autopsy findings ailable prior to mpletlon of ceuse deeth?
The page	3	Hypothyroidism,	Respirator	y Ins	uffic	iency	,		10	Yas 2 No	10	☐ Yas 2☐ No
Physicien: The is this certificate he ral director, page	Be	25. Was casa rafarrad to medicel axaminer?						26. Placa of De	eth (Check only	ona)		
this c	2	1 ☐ Yas 2√2 No	Hospitai:		VOutpatient		^		Homa 5 ☐ Resi	dence 6 □Ot	har (Specif	(y)
	Certification:	27. Manner of Deeth  1 X Naturel 5 Pending  2 Accident invastigetion  3 Suicida 6 Could not be		y Year) 21	8b. Tima of Injury	M 28	Bc. Inju Wo 1 □	ry at rk?   Yas 2 □ No	28d. Dascribe	how injury occu	rred	
ital or At irs aftar al Directied in by		4 Homicida datarminad	28a. Place of Injubuliding, atc	ury - At hom: c. (Spacify)	a, farm, stre	eat, factory,	, office		28f. Location ( City or To	Street and Num wn, Stata)	ber or Rura	al Routa Number,
To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	29e. Certifiar (Check only one)  Certifying Physician: To tha best of my knowledga, daath occurred et tha tima, date an advance on the basis of axaminetion and/or invastigation, in my opinion, daa end mannar stated.							ma, date and pleo opinion, daath occ	ee, end dua to tha curred at tha tima,	causa(s) end m data and place	annar as si , and dua to	tated. o tha cause(s)
To the within 2 To the comple	Σ	29b. Signature and titla of certifiar				29c.	Licans	e numbar		29d. Data signa	ad (Month,	Day, Year)
		Myrne		Sic	1	)	D34	472		Septemb	er l.	1998
2)	-	30. Nama and address of person who o	complated ceuse of de	aath flom 2	3a) (Vine F							
4		Dr. Lynne Digg					Roa	d, Silve	r Spring	, Maryl	and	20910
Sta	te	31. Data filad (Month, Day, Year)	Separa	Signetur	9.	ha	1	,				

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- PF X E X F III 381

	1. Decedent's Name (First, Middle	a. Last)		Certificate	011	Death	2. Date of D	Reg. No.	Law.	3. Time of Death
ian cal	James B.	Thomson					Month Augus	Day	Year 998	10:00 pm
ier	4e Fecility Neme (If not institution	, give street and number	er)				or Location of Dec	eth 4c. County	of Death	
	2112 Beechwood					Hyatts				orge's
	5. Social Security Number 579-14-9399 Usual Residence of Decedent	6. Sex 1 M 2 □ F	Age (In yrs. lest	Yrs. If Under Months	Days		Ain. (Month, I	Birth Day, Year) 18, 1919		elece (State or Fore etry) 1esota
	10a. State 10b. County		10c. City, T	own or Location					1	0d. Inside City Lim
tor	Maryland Prince	e George's		Hyattsvil	1e					1 ☐ Yes 2 🔯 I
Directo	10e. Street end Number			10f, Zip				10g. Citizen of	Whet Cour	ntry?
a C	2112 Beechwoo	od Road			207	783		U.S.	Α.	
oy runeral	11. Maritel Status  1 □ Never Married 2 ☑ Marri 3 □ Widowed 4 □ Divorced	12. Wes Deceder Armed Force ed 1 X Yes 2 ( If Yes, Give Year or Date:	□ No	13. Wes Deceded If Yes, special 1 Yes 2		dispanic Origin? an, Mexican, Pu Specify:	? (Specify Yes or f uerto Rican, etc.)	No- 14. Rac Bla Specifi	ck, White,	
	15. Decedent		AA AA T T	6a. Decedent's Usua	I Occup	ation		16b. Kind of B	usiness/Inc	dustry
combiered by	(Specify only highes Elementery/Secondary (0-12)			(Give kind of work life. DO NOT use	k done	during most of	working	37 16		
	12	College (1-40	,, 5+,	Carpenter				Const	ructi	on
	17. Father's Name (First, Middle, I	Last)				18. Mother's I	Name (First, Midd	lle, Maiden Sumen	ne)	
)	James Thomson							Black		
	19e. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailing Address						
	Sarah G. Thomso:	n - Wife		2112 Beech			Hyattsv	ille, Ma:		
	1 🕅 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		(e	e of Disposition (Nem etery, crematory or of Lincoln (				Brentwo		
	21. Signature of Fundual Service I	Jean W	est.	Gasch 4739 B	's I	Funeral	Home	yattsvil:	le. M	D 20781
	23a. Pert1. Enter the disease, processions, or heart failure.		no.						i	Interval Between
	Immediate Cause (Final disease or condition resulting in death)	& Car		Loma	0		-			Onset and Death
niner	disease or condition resulting in death)	& Car	Due to (or as	s a consequence of):	0		-		1	Onset and Death
ai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	6	Due to (or as		0		-			Onset and Death
dicai	disease or condition	to. Con	Due to (or as	s a consequence of):	0		0	rosto	le	Crise: and Death
in de la	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	6 c	Due to (or as	s a consequence of): s a consequence of): e consequenca of):	lo	ofu	le p	d tobacco use co	ontribute to	o the cause of dea
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commeasure to be completed by any steam and any	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Part II. Other significant condition  Part II. Other significant condition  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Neturel investig investig all causes investig all causes investig all causes investig all causes. In the could not be a could not be	b	Due to (or as	s a consequence of): s a consequence of): s e consequenca of): g e consequenca of): g in the underlying ca the underlyin	ause given	ren in Part I.  26. Plece of her: 4 Nursin Yet X? Yes 2 No	23b. Di 10 24a. Wi pe 11 Death (Check on) ing Home 5 M Re 28d. Describ 28f. Location City or 7	d tobacco use co Yes 2 No as an autopsy rformed?  Yes 2 No y one) asidenca 6 Ott be how injury occur of (Street end Numi rown, Stete)	24b. Wave coof	bably 4 dunkr ere autopsy findin allable prior to mpletion of cause death?  Yes 2 No
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 9:55 AM SYDNEY EMANUEL TOLSON 28 1998 August /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Prince George's Cheverly If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) If Under 1 Year Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) Funeral Months Days Hours 10XM 2□ F 577-09-6928 91 October 8, 1906 Maryland Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d Inside City Limits Mary land Howard 1 X Yas 2 No Director Columbia 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 6164 Llanfair Drive 21044 U.S.A. 14. Race - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status 12. Wes Decedant Ever in U,S. Armed Forces? filed within 72 hours after 1 ☐ Yas 2 ☑ No If Yes, Give Yeer or Detes: 1 Nevar Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) Collega (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien. Important: If Nem 27 is marked other that any Injury or other traumetic entering once. Laborer Government 9th 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Be William Tolson James Julia Dver 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Audrey Smith/Niece 6164 Llanfair Drive, Columbia, Maryland 21044 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 109/03 1 X Burial 2 ☐ Cremation 3 ☐ Removel from Stete Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 1998 J.B. JENKINS FUNERAL HOME 21. Signeture of Funeral Service Licensee Va 7474 Landover Road, Landover, Maryland 20785 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel Myo Can dia disease or condition resulting in death) Examiner Examiner physician and s the burial-transit that the death certificate be axecuted Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as e consequence of) Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) BSI Part II. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yee 2 ☑ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy parformed? paga 2 s 1 ☐ Yes 2 ☐ No cartificata Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2√ No 1 Inpatient 2万€R/Outpatient 3□ DOA this 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? Aftar 1 Netural 5 Pending n 24 hours after death.

Ne Funeral Director: After plataly filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homiclde Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner es steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Nema and address of parson who completed cause of deeth (Item 23a) (Type, Print) Rakesh Arora, M.D., 14300 Gallant Fox, Suite #222, Bowie, Maryland 20715 31. Dete filed (Month, Dey, Year) 32 Registrar's Signeture State AUG 3 1 1998 Registrar

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month AUGUST 28,1998 11:15 am ALLEN SPENCER THOMAS 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) CLINTON PRINCE GEORGES MARINER HEALTH CARE Birthplace (State or Foreign Country) If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months Hours XXM 2DF OCTOBER 15,1909 WASHINGTON DC 88 577-60-7225 Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County N☐ Yas 2 ☐ No WASHINGTON DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4436 DOUGLAS ST N.E. 20018 UNITED STATES 14. Race - American Indian, Black, Whita, etc. 11 Marital Status 12. Was Decedent Evar in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 1 □ Never Married 2 □ Married 1 XYes 2 No 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Gollege (1-4or 5+) Elementary/Secondery (0-12) FED GOVERNMENT POSTAL CLERK 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) MOLLIE STEWART SPENCER H. THOMAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 16745 SUNDERLAND DETRIOT, MICH. 48219 CHARLES W. THOMAS jr./NEPHEW 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition FORT LINCOLN CEMETERY 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-2-98 BRENTWOOD , MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOME Part Lenter the disease or complications that causad the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5538 MARLBORO PIKE FORESTVILLE, MD 20747 Approximate Interval Between Onsat and Death Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or as e consequença of): Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? 1 Yas 2 No 3 Probably 4 Unknown BLOW 24b. Were autopsy findings available prior to completion of ceusa of death? 24a. Was an autopsy performed? 2 1No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28d. Describe how Injury occurred

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Director

Funeral

by

Completed

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Examiner

**Funeral** 

Director

8 0/8

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-1 show any fujury or other traumatic event, the Medical Examiner must be notified at page.

Baltimore, Maryland 21215-0020

physician and s the burial-transit 88 USB signed t hes

requires that the death certificate be executed

certificate he this funeral After

Examiner Physician/Medical þ leted Be To 6

Division of Vital Records, P.O. Box 68760, Certification: Attending death. or Attendation of the other deat A 24 hou. Funeral Dr. edical To the Within 2 To the

State Registrar

1 Natural 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and mannar stated.

29b. Signature and title of certifie

SEP

28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury at Work?

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

ALREIT

29d. Date signed (Month, Day, Year)

30. Name end address of person who completed cause of death (Item 23e) (Type, Print) E MAN

RE 31. Date filed (Month, Day, Year) 0 1 1998

32. Registrar's Signature

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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death	Reg. No.	0525
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Physician /Medical	Mamie Lou	Tull	AUGUST 31,195	the same same
Examiner	4a Facility Nama (If not institution, give street and number)	4b. City, Town, or Loc		Death
N-L	PENINSULA REGIONAL MEDICAL CENT		RY WICOI	MICO
Funeral Director	5. Social Security Number 6. Sex 1 M 2 XF 7. Aga (In yrs. In Usual Residence of Decedant	st birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Data of Birth (Manth, Day, Year)	9. Birthplace (State or Foreign Country)
ylend	10a. Stata 10b. County 10c. City,	Town or Location		10d. Inside City Limits
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- N 6	19a, Informant's Name/Ralationship (Type, Print)	19b. Meiling Address (Street and Number or Rural	Route Number, City or Town, St	tate, Zip Code)
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	Galad Placher	019289	8/31,	198
	30. Nama and address of person who completed cause of death (Item 2		0 / 1	,
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Balti	permit. Pages 'Department of F Important: If ite any injury or or phose.	21. Signature Funeral Service Licron  22. Name end Address of Fecility ALEXANDER S. POPE FUNERAL HOME 5538 MARLBORO PIKE FORESTVILLE, MI											.7
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State of Maryland / Department of Health and Mental Hygiene

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/Medic		4e. Facility Neme (If not institution, gi	ve street and number	or)			4b. City, Town,	or Location of Dee		of Deeth	9,29
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Funeral Director		214-70-3971	Sex 1 ☑ M 2 ☐ F	Age (In yrs. 54	last birthdey) Yrs.	If Under 1 Y Months De	eer If Under 24 H	rs. 8. Dete of B	irth ley, Year)		(State or Foreign
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or items	by Funeral Director	11. Maritel Status  1 ☐ Never Married 2 ☒ Merried 3 ☐ Widowed 4 ☐ Divorced	12. Wes Deceder Armed Force 1 Yes 22 If Yes, Give Yeer or Detes	s? I No		Ves Decedent Yes, specify (	of Hispanic Origin? Cuban, Mexican, Pu No Specify:	(Specify Yes or Nerto Rican, etc.)		ce - American I ck, White, etc.	
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the a	ysic	Pert II. Other significant conditions	contributing to death	but not res	ulting In the ur	derlying cause	given In Pert I.	23b. Dic	I tobacco usa co	intributa to the	cause of death?
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то тр		29b. Signature end title of certifier				-29c. Lic	ense number		29d. Date signe	d (Month, Day,	Year)
		man am	J. Mel	2m		D	23743	3	8-3	31 -98	)
		30. Name end eddress of person who									

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. Amend: #5 Per Informant Film G7 State of Maryland / Department of Health and Mental Hygiene 98 28528 Certificate of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath Day Year **Physician** AARON WASHINGTON AVOUST 29 1030 TAMES JA 1998 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SILVER SPUB 14212 MAYGATE ON UT MONTGOMERY If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 2/17/15 9. Birthplace (State or Foraign 7. Aga (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours ASHEVILLE, NC 5<del>88</del>-Yrs. 18 83 Director Usual Rasidance of Dacedant 10d. Inside City Limits 10a Stata 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filled within 72 hours efter death with the Merylen Department of Heelth and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Modical Examiner man be notified at DEC. 1 Yas 2 No Directo MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 14212 NORTHGATE DRIVE 20906 USA Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ②No If Yas, Give Year or Datas: 14. Race - American Indian. 11. Marital Status Black, White, atc. 1 □ Navar Marriad 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: Specify: BLACK by 3 Widowed 4 □ Divorced Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Dacedant's Education (Specify only highest grada complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) 12 YEARS 5 YEARS JUDGE LEGAL PROFESSION 18. Mothar's Nama (First, Middla, Maiden Surname) 17. Fathar's Nama (First, Middla, Last) Be VIVIAN ALSTON JAMES AARON WASHINGTON SR. 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) DIANA W. SMITH (DAUGHTER) 4400 14TH STREET NE, WASHINGTON, DC 20017 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Burial 2 M Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN MEMORIAL CEMETERY 9/4/98 SUITLAND, MD. 22. Nama and Addrass of Facility

JOHN T. RHINES CO., INC. 21. Signatura of Funaral Service Licansea 3030 12TH ST NE, DC 20017 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death Physician DUCESTIVE THAPH /Medical Immediata Causa (Final diseasa or condition rasulting in death) Examiner Dua to (or as a consequance of): Examiner physician end the burial-transit certificate be executed Sequentially list conditions, if any, laading to immadiata ceuse. Enter Underlying Causa (Disease or injury that initiated evants rasulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 98 USB signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to complation of ceusa of death? Completed 24a. Was an autopsy performed? page 2 s 2 NO 213NO 1 Yas 1 ☐ Yas certificate or Attending Physician: funeral director, 25. Was cese referred to medicel Be 26. Placa of Daath (Check only ona) examiner≀ 1 Nas 2 No Other: 4 Nursing Homa 0 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 5 Rasidance 6 Othar (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 5 Panding efter death. 1 Yas 2 No invastigation 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 ☐ Homicida 24 hours e Hospital 29a. Certif 1 Cartifying Physician: To tha best of my knowledge, daath occurred at the tima, data and place, and dua to tha causa(s) and mannar as stated. Medical completely Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. To the within 2 29b. Signal 29d. Date signad (Month, Day, Year) od title of certifier 29c. Licansa number

2 State

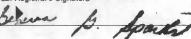
Registrar

31. Date filed (Month, Day, Year)

CALL I. WARGOUS, MO. 11125 ROCKVILE PIKE, ROCKVILLE, MO 20852 32. Registrar's Signatura

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

SEP 0 3 1998



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AUGUST 24, 1998

TO THE PARTY OF A CASE OF THE The second secon

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month Day Yeer 2245 PM **Physician** AUGUST 29, 1998 RICHARD E. WALKER /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner PRINCE GEORGES HOSPITAL CENTER CHEVERLY PRINCE GEORGES If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Days Min. 1 M 2 F Months Hours Yrs Director 578-06-7345 11/5/66 WASHINGTON. DC Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 10e. State 1 Yes 2 No Directo 28a-f MONTGOMERY SILVER SPRING 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Herris 23a or 3 Iner must be n 20902 USA 10528 GEORGIA AVENUE Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerlo Ricen, etc.) 14. Rece - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status natural, or item oficel Examiner Bleck, White, etc. 1 Yes 2 No 1 Never Married 2 Married BLACK 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorcad Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) the i POSTAL SERVICE US POSTAL SERVICE 12 YEARS NONE 17 Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be 2 and Mental Pages 1 and 2 should be threat of Health and Menta tart: If them 27 is marked jury or other traumatic ev CAROL LIGHTFOOT EARL DEXTOR WALKER 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Belationship (Type, Print) CARLA D. WALKER (WIFE) 10528 GEORGIA AVENUE, SILVER SPRING MD., 20902 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) LINCOLN MEMORIAL CEMETERY 9/4/98 SUITLAND, MD. 22. Name and Address of Fecility JOHN T. RHINES CO., INC. 1021. Signal Funeral Service I Icanium 3030 12TH ST NE, DC 20017 ucen 23e. Part I nter the disease, or complications that caus show or heart failure. List only one cause on each Approximate Interval Between Onset end Deeth +caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examine Examiner end I-trensit thet the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): physicien er Box 68760 Physician/Medical Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. detach 1 Yes 2 No 3 Probably 4 Unknown 2 Be l 24b. Were autopsy findings eveilable prior to Completed 24e. Wes en autopsy completion of cause of death? is certificate hes t director, page 2 s The 1 Yes 2 No 2 No or Attending Physician: after death. Director: After this certific Be 25. Was case referred to medical exeminer? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) XXXYes 2□ No Certification: To 1 ☐ Inpatient 2 ☑ ER/Outpetient 3 ☐ DOA funeral 28d. Describe how injury occurred Drivery Motorcycle operator Collides with van 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 1 Naturel 5 Pending 29/98 2200 M 1 Yes 2 No Investigation 2 Accident by the 28e Place of Injury - At home, farm, street, factory, office building, etc. (\$pecify)

1 Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated. 3 Suicide 6 Could not be determined 4 ☐ Homicide A 24 hour. Ne Funeral Dir. To the Hospi within 24 hours To the Funer completely fill 29a, Certifier Medical (Check only one) end manner steted 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number

State Registrar

SEP 0 3 1998

Josep

31. Date filed (Month, Day, Year)

30. Name and endress of person who completed cause of deeth (Item 23e) (Type, Print) restaner

> 32. Registrer's Signeture Sports

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

AUGUST 30, 1998

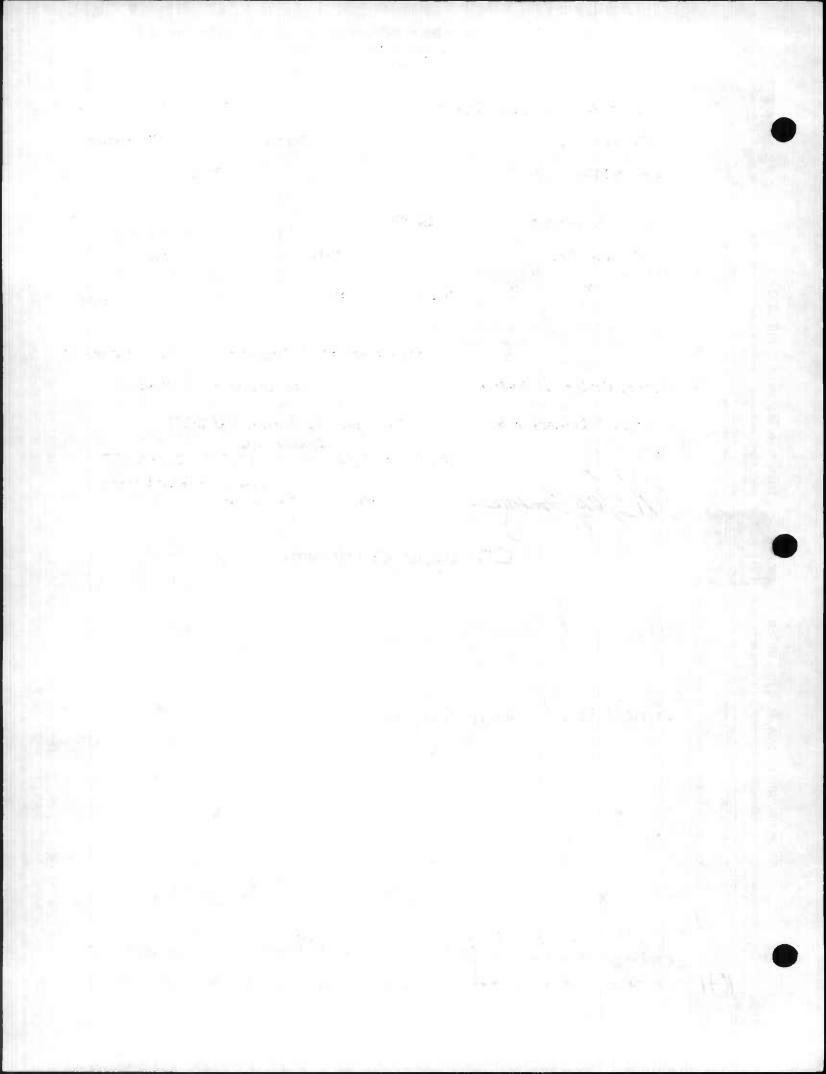
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DHMH 16 Ray 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 24 98 1:25 AM Francis van der Veer Walker 8 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Worcester 8. Date of Birth (Month, Dey, Year) If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1XM 2□ F Yrs. 77 044-12-5138 9/29/20 Director Usual Residence of Decedent the Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th end Meniel hygiene.
7 is marked other than "nature!", or items 23s or 28s-f show treumstic event, the Medical Exemples must be notified as 150 Yes 2 □ No Director MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours efter deeth with 101 Ann Dr. 21811 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Bleck White etc. 1 Never Married 2 Married 1 XYes 2 □ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 HWW 1 ☐ Yes 2 No Specify Specify: à 3 Widowed 4 Divorced white Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Structural Steel Engineer Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 end 2 should be fill ment of Health end Mentel Hant: if item 27 is marked oth jury or other treumatic even Be Dorothy van der Veer Robert Craighead Walker 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Margaret Walker/ Wife 101 Ann Dr. Berlin, MD 21811 20b. Place of Disposition (Name of Comurchyard Date cametery, crematory or other padurchyard 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: if any Injury or once. St. Paul's Episcopal 8/27/98 Berlin, MD 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Puneral Service Licensee 108 William St. Berlin, MD 21811 Approximate Intervel Between Onset and Death ications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, as cause by each line **Physician** cholangio Immediete Ceuse (Finel disease or condition resulting in death) /Medical Caranoma. Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physicien end s the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of). Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) d for use as t the Pert tl. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown adeno Caranoma PV been signal 24b. Were autopsy findings eveilable prior to completion of ceuse of deeth? 24a. Was an autopsy Completed is certificate has b director, page 2 sl 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was cese referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nasidence 6 Other (Specify) 2 1 Yes 2 No this funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: , 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) Hospital or At 24 hours efter 4 I Homicide in 24 hours et the Funeral Di pletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the ceuse(s) and menner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and menner stated. 29a. Certifier Medical To the To the Comple 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) CHANDRASEKHARA SALKBURY MD 21801. KOTA 306 KAY AVE 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State AUG 2 6 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth 3. Time of Death **Physician** WALTER MARY MARGAREE AUGUST 1998 5:20 PM /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Berlin Nursing and Rehabilitation Center Berlin Worcester If Under 1 Year Months Days If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex **Funeral** 8. Data of Birth (Month, Day, Yeer) Birthpiece (State or Foreign Country) 1 M 2 € F Days 95 173-50-9498 Director 5/22/03 MD Usual Residence of Decedent the Maryland 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show the Medical Example, must be notified at 1 Yes 2 No Director FLLee Bonita Springs 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 26149 Colony RD 34135 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian Bleck, White, etc. 11. Merital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: by 3℃ Widowed 4 Divorced Specify. white Completed 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) permit. Pigges 1 and 2 should be filed with Department of Health and Mental Hygien Important if item 27 is marked other than any Injury as other transmets. Housewife 6 Home 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Malden Sumame) Be Julia Elizabeth Rippen Samuel Cromwell 19e. Informent's Neme/Ralationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Beulah Eby/ Daughter 10640 Worcester Hwy. Berlin, MD 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 XBuriei 2 ☐ Cramation 3 ☐ Ramovai from State Bethel Cemetery 5 Other (Specify) Cascade, MD 4 Donation 8/31/98 21. Signature of Fu mi S 22. Neme end Addrass of Facility vice License Burbage Funeral Home 108 William St. Berlin, MD 21811 complications that clused the deeth. Do not anter the mode of dying, such as cardiac or raspiratory arrest, and one cause of each line. Approximate tnterval Between Onset and Deeth **Physician** otic Cardiovaccules I /Medicai Immediate Ceuse (Finel diseese or condition resulting in death) Examiner Examiner buriel-trensit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest end Due to (or es e consequence of): Records, P.O. Box 68760 physician Physician/Medical the Dua to (or es e consequence of): ettending p signed by the e Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were eutopsy findings available prior to completion of causa of death? 24e. Wes en eutopsy performed? s certificate has blirector, page 2 s 20 No Division of Vital To the Hospital or Attending Physician: within 24 hours efter deeth.

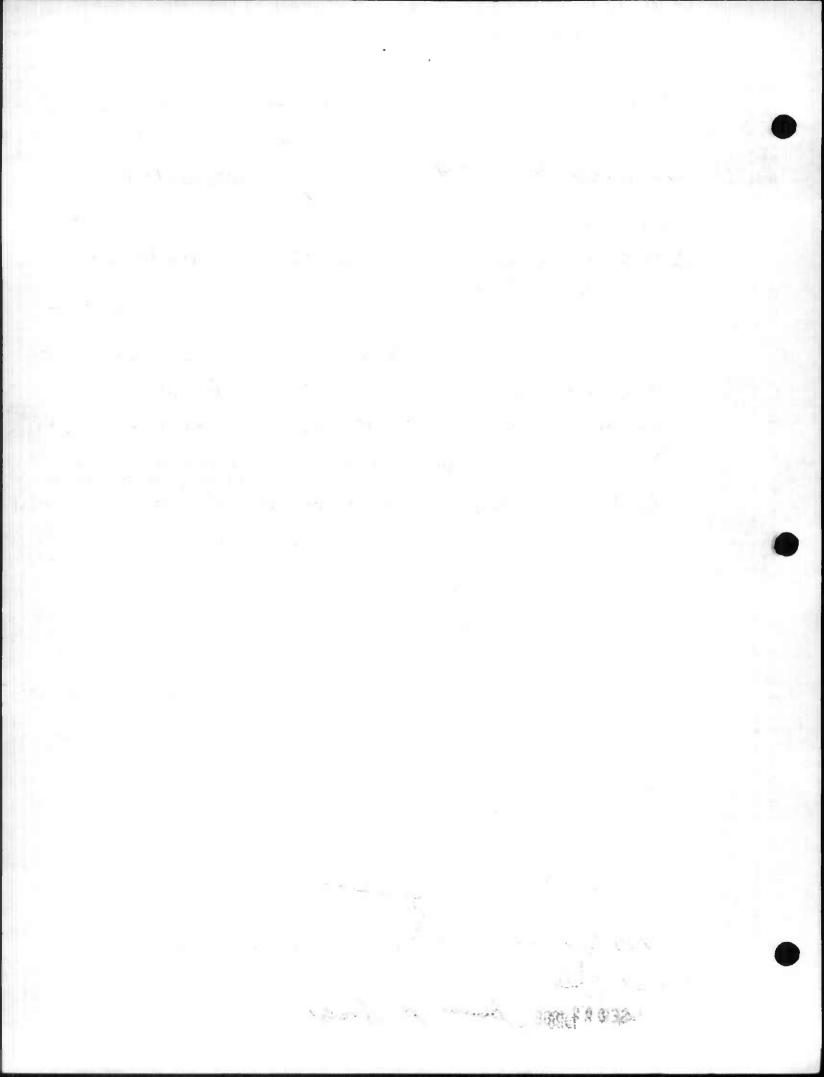
To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) examiner? Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Lo 27. Menner of Dee 1 Neturel 2 Accident 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Yes 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner es steted.

2 Medical Examinar: On the basis of examination end/or invastigetion, in my opinion, deeth occurred et the time, date end plece, end dua to the cause(s) end menner stated. Medical (Check only 29b. Signature end title of certifier 29c. License number 29d. Data signed (Month, Dey, Year) 8-28-98 Name and accounts of person who completed cause of deeth (Item 23e) (Type, Print) GREGORIO M. BELLOSO, MD. 5302 CHINABERRY DRIVE, SALISBURY, MD 21801
31. Dete filed (Month, Day, Year)
32. Registrer's Signetura State AUG 3 1 1998 Registrar

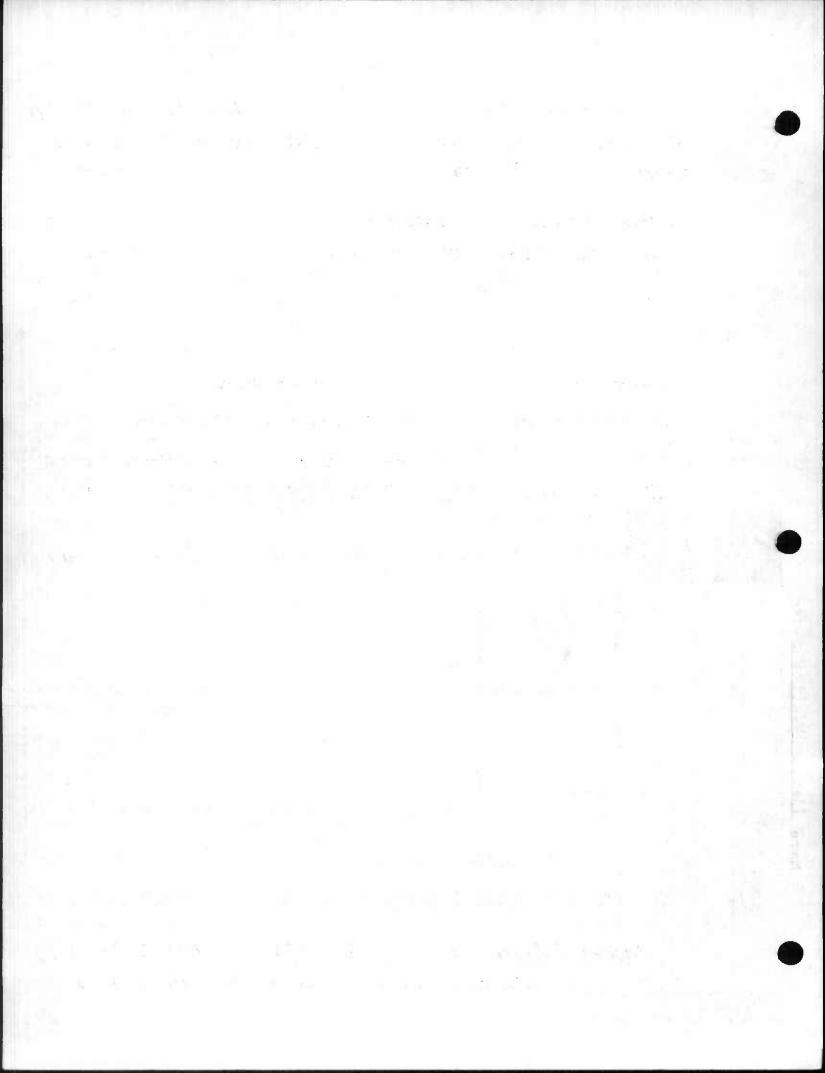
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State of Maryland / Department of Health and Mental Hygiene 9 9 5 3 3

			Certificate of Death	Reg. No.	20000
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/Med Exam		4a. Facility Nama (If not institution, giva street and number) GOOD SAMARITAN HO	SPUTAL BALTIN	cation of Death 4c. County o	MORE CITY
Funera Directo		5. Social Sacurity Number 6. Sax 7. Aga (In yrs. le 1 M 2 F  Usual Rasidence of Decedant	ast birthday) Yrs.  If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Data of Birth (Month, Day, Year) 09-23-18 \(	9. Birthplaca (Stata or Foreign Country)  1. R. G. IFI A
5-0020 72 hours after death with the Maryland netural; or Items 23a or 28a-f show deal Examiner must be notified at	Funeral Director	Md Balfimire Bal  10e. Street and Number  23/ E. LAFayeTTe 57  11. Marital Status  1 Navar Marriad 2 Married  1 Yas 2 No	Town or Location  10f. Zip Coda  2/202  3. Was Decedent of Hispanic Origin? (Spelf Yas, specify Cuban, Maxican, Puarto I		10d. Insida City Limits  1 □ Yas 2 □ No  nat Country?  States  - Amarican Indian, , Whita, atc.
21215-0020 d within 72 hours af plena. r than "natural", or the Medical Exam	ted by	3 Wildowed 4 Divorced Yaar or Datas:	16a. Decedant's Usual Occupation	Specify:	/3/ACK_inass/industry
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Itimore, Mar it. Pages 1 and 2 sh riment of Health and riant: If item 27 is m		19a. Informant's Name/Ralationship (Type, Print)  Sed	19b. Mailing Addrass (Street and Number or Rura 3485 Willow ST aca of Disposition (Nama of matary, crematory or other place)	Date 20c. Location - C	City or Town, State
Dem Permi		Keth E, whaten	22/71 wh sorter	RI Acc	umbe Va 332
Physician /Medica Examine			renal Failure as a consequence of):	raspinatory areas,	Interval Batween Onset and Death
Box 68760, eath certificate be axecuted attending physician and for use as the burial-transit	VMedical Examiner	if any, leading to immediate cause. Enter Underlying Cause. (Disease or Injury c. Cancev	as a consaquanca of):  of the prostate as a consaquanca of):		
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To the Howithin 24 To the Fu	Medical	one) and manner stated.	on and/or invastigation, in my opinion, daath occurre		
or with			29c. Licansa number P11402	AUGUST	(Month, Day, Yaar) 22, 1998
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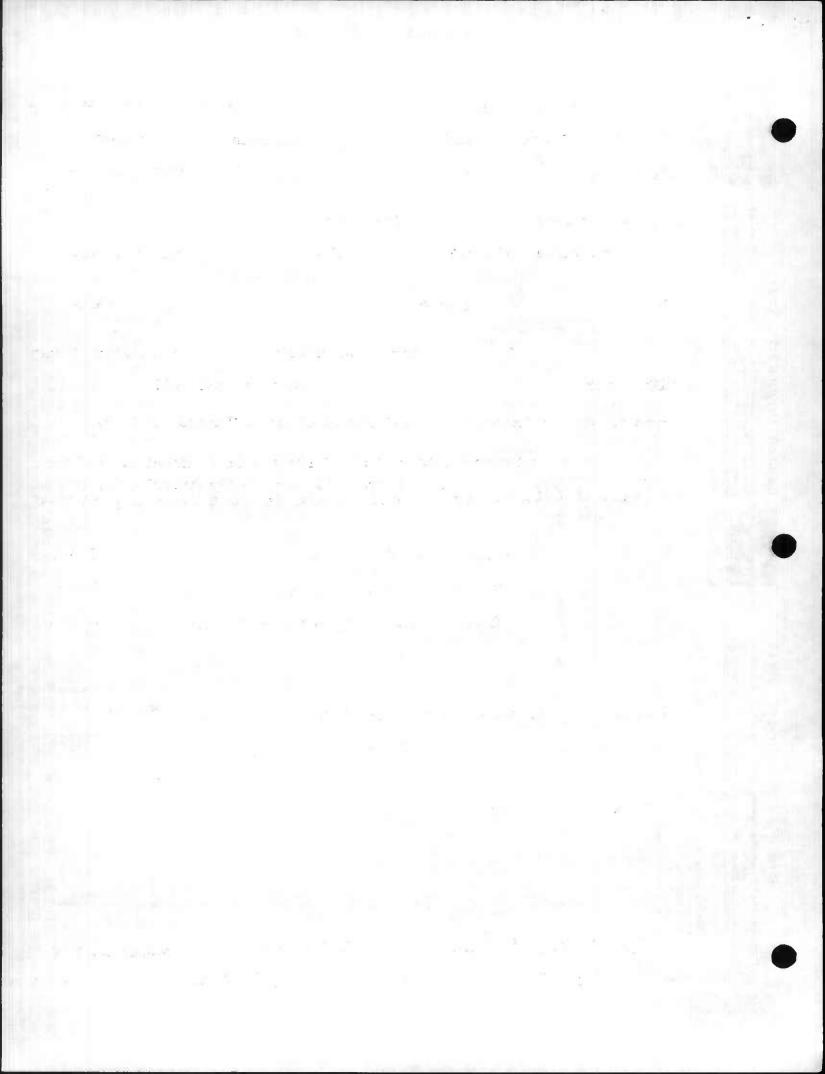


		Decedent's Name (First, Middle, Last	st)		Certificate of	Dealli	2. Date of De	Reg. No.		3. Time of Death
Physic		Marie Wal	terhoefer				Month	Day 7 1	Yeer a O	8:30 pm
/Medi Exami		4e. Facility Name (If not institution, give			TELE .	4b. City, Town, or	Location of Deal	h 4c. County	98 of Death	6.2- pm
Funeral Director		5. Social Security Number 6. St 215-22-3095	Care Ce	nter . last birtho Yr	Months Devs	CATOR If Under 24 Hrs Hours Min.		e Bo	11	I Va er L lece (Stete or Foreign try) Land
pue M.		Usual Residence of Decedent  10a. State 10b. County	10c. C	itv. Town o	or Location				1	Od. Inside City Limits
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r 28a	Director	10e. Street end Number	16	cawi	10f. Zip Code			10g. Citizen of	What Coun	
h with		407 Maiden Choice	Lane Room 41	7 Sou	th 21228	3		Unite	d Sta	ates
efter or ite	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Yeer or Dates:	J,S.	13. Was Decedent of I- If Yes, specify Cub- 1 ☐ Yes 2 XNo	dispanto Ortgin? (Sen, Mexican, Puerl Specify:	pecify Yes or Note Rican, etc.)	5- 14. Rac Blac Specify	ce - Americ ck, White,	
72 hours "natural",		15. Decedent's Ed	ucation	16e. D	ecedent's Usual Occup	pation		16b. Kind of B		
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d 2 st th and 7 is n traun		19a. Informant's Name/Relationship (7			Mailing Address (Street					
Health em 27 other tr		Joseph Walterhoef 20a. Method of Disposition	20b.	Place of D	21 Old Fred isposition (Name of		Dete Dete	20c. Location	-	
permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiena. Important: If item 27 is merked other than any injury or other traumatic event, the Monce.		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	cemetery,	cremetory or other plea	1	177			
permit. Page Depertment of Important: If any Injury or once.		21. Signature of Funeral Service Licen:		udon	Park Cemet 22. Name and Addre		8-25-98	Baltimo	re, I	Maryland
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		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	1000	th. Do not	4112 Old C	Columbia	Pike El	licott C	ity,	
Physiclan		shock, or heart failure. List only o	one cause on each line.							Approximate Interval Between Onset and Deeth
/Medical		Immediate Cause (Final disease or condition	End st	AMP	Conges?	tive H	eart	failu	40	Ugas
Examiner		resulting in death)	a. Due to (	or as a cor	rsequence of	100 11	ear c	1 2010	1	Jear)
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ficete be execute physician and s the burial-trans	Examiner	Sequentially list conditions,	Due to (	or as a cor	nsequenca of):					
ficete be executed physician and s the burial-transi	ie E	Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury	c							
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quiras n sig uld bu	d be						24a. Was	an autopsy	24b. We	ere autopsy findings
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The law requires that the death certi- rate has been signed by the attanding pega 2 should be datached for use a	Completed by						10	Yes 2000		Yes 20 No
	Be C	25. Was case referred to medical				26. Place of Dea				24.10
is cer direc	ToE	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpa	atient 3 DOA Oth	or: A		dence 6 □Oth	er (Specify	<i>(</i> )
aing Physician: h. After this certific funeral director,		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Dey Year)	28b. Tim Inju	e of 28c. Injur			how injury occur		,
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17		30. Name and eddress of person who c			pe, Print)	, Catons	1.11-	1.0	7,7	70
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# . Amended #5,09/04/98, PCT, Howard Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

mended #12,	8-28-98, M.W.O., Howard Co.	yland / Department of Certificate of		entai mygien Reg. N	7.7	28535
Physician	Decedant's Nama (First, Middle, Last)				ey Yee	
/Medical	Clifford R. Walter	s Sr.	4b. City, Town, or Loc		25 1998 lc. County of De	
Examiner	4a Facility Neme (If not institution, give street and number) Howard County General Hospit	al	Columb		HOWa	
Funeral		In vrs. last birthday) If Under 1 Yaa		8. Dete of Birth (Month, Day, Yea		tirthplace (State or Foreign Country)
Director	5. Social Security Number 6. Sex 1.4 M 2 F 7. Aga (1.2 M 2 F 7. Ag	Yrs. Months Deys	s Hours Min.	Oct 9, 19	19 Ma	aryland
pue *	Usual Residence of Decedent  10a. State 10b. County 1	Oc. City, Town or Location				10d. Inside City Limits
the Maryle r 28a-f eho noutre	Maryland Howard	Ellicott Cit	57			1 ☐ Yes 2♥ No
in the Marylen or 28s-f show be notified.	10e. Street and Number	10f. Zip Code	χ	10g. C	Citizen of Whet	Country?
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urs effer dee	11. Merital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Wes Decedent Eva Armed Forcas?  12. Was Decedent Eva Armed Forcas?  12. Wes Decedent Eva Armed Forcas?  12. Wes Decedent Eva Armed Forcas?	1944-46 If Yes, specify Cu	Hispenic Origin? (Speben, Mexicen, Puerto For Specify:	cify Yes or No- Ricen, etc.)	14. Race - Ar Black, Wi Specify:	nerlcan Indien, hite, etc. White
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aryland 212 should be filed within the Mental Hygiene. In marked other then umatic event, the M	Wilbur Walters		Mary Eli	izabeth Ha	all	
S she and and s mu	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street				
	Marsha A. Karceski/Daughter	14605 McClin			MD 217	
Baltimore, pemit. Pages 1 er Department of Haa Important: If item 2 any injury or other once.	1   Burial 2   Cremation 3   Hamoval from State	20b. Place of Disposition (Name of cemetery, crematory or other page 200).				
Baltimol Permit. Pages Department of Important: If it any injury or o	4 Donetion 5 Nother (Specify) entombment					
Balti permit. Departin importa any info	I Som a Collins- with	4112 Old (	ress of Facility Witzke's Fa Columbia P	ike Ellico		, MD 21043
Physician (Modical)	23a. Part1. Enter the disease, or complications that causad h shock, or heart failure. List only one cause on each line.	a daath. Do not anter the mode of d	ying, such as cardiac o	i lespiratory errest,		Approximate Interval Between Onset and Death
/Medical Examiner		ation Preonen	14			3 2442
The second		te to (or es a consequence of):				4wks
of Vital Records, P.O. Box 68760, Physician: The law requires that the dash certificate be axecuted this cartificate has been signed by the attanding physician and relidirector, page 2 should be datached for use as the burial-transit or to be completed by Physician/Medical Examiner: To Be Completed by Physician/Medical Examiner:	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury	a to (or as a consequence of):	on known	Orisin		4 w/L)
P.O. Box 687 at the death certificate they the attanding phys attached for use as the Physician/Medic	that initiated events resulting in death) Lest	e to (or as a consequence of):				1
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Division of Vital Records, F or Attending Physician: The law requires tha after death.  Director: After this cartificate has been signed in by the funeral director, page 2 should be datertification: To Be Completed by P	Anorexia / Cachexia	Syndrai		24a. Was en eu performed?		b. Ware eutopsy findings available prior to completion of causa of death?
The law ate has page 2:				1 ☐ Yes	25100	1 ☐ Yes 2 ☐ No
Vital Indicion: The cardificate rector, pag	25. Was cese referred to medicel		26. Plece of Death		-34.10	.2.00 22.00
Of Vital Physician: 1 this cartifica rel director, p	examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 □ ER/Outpatient 3 □ DOA	Wher	me 5 Residence	6 □Other (S	pecify)
ion o nding Ph ath. :: After th e funerei	27. Manner of Death 1 Natural 5 Pending (Month, Day Y	(ear) 28b. Time of 28c. In W	jury at /ork? □ Yes 2 □ No	28d. Describe how in	jury occurred	
_ 855 O	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (	9	28f. Location (Street City or Town, St	and Number or ate)	Rural Route Number,	
he Hospii in 24 hou he Funer pletely fill edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of n 2 Madical Examiner: On the basis of exam menner state.	amination end/or investigation, in my				
To the common N	29b. Signature and title of certifier		36573			onth, Day, Year)
8	30. Name and address of person who completed cause of deer	5				26, 1998
State	31. Data filed (Month, Day, Year) 32. Registrer's	signature G. A.		14x 1cmd	7 00 10	TOWN HIDE
Registrar DHMH 16 Rev 6/95	AUG 2 6 1998 > 5	p. A.	portal			



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3 8 Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Wooster 5 PM 4b. City, Town, or Location of Death 4c. County of Death Laure Welch's 6 Sex If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Birthplace (State or Foreign Country) Months Deys Hours Min. 1 M 2□ F 216 36 7544 Yrs. 59 August 23,1939 WashingtonD.C Usual Residence of Decedent 10e State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XXNo Maryland Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3285 Welchs Court 20724 USA 12. Was Decedent Ever in U,S. Armed Forces? 14. Wes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14 Race - American Indien 11 Marital Status Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: 34 Widowed 4 □ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Grade 12 Construction Worker Cable Reel Company 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Paul Bassett Wooster Hazel M. Walker 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Walter P. Wooster brother 11234 Cherry Hill Rd. #101 Beltsville, Md. 20c. Locetion - City or Town, State 20705 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Burial 2 Cremation 3 Removel from State Ft. Lincoln Cemetery 8/31/98 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Donaldson Funeral Home, P.A. (n 313 Talbott Avenue Laurel, Md. 20707 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth covonary vascular disease Immediate Cause (Finel disease or condition resulting in death) hupertension Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or as e consequence of): Due to (or es e consequenca of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? diabetes 1 Yss 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to 24e. Was en eutopsy completion of ceuse of deeth? 2 No 1 Yes 2 No 1 TYes

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Dete signed (Month, Day, Year)

**Physician** /Medical Examiner

**Physician** 

/Medical

Director

Funeral

þ

Completed

Examiner

**Funeral** 

Director

Item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at

2 should be filed within 72 hours effer on end Mental Hygiene. Te merked other than "naturet" or have

permit. Pages 1 and 2 st Department of Health end Important: If Item 27 is m any Injury or other traum

Maryland 21215-0020

Baltimore.

Box 68760

Division of Vital Records, P.O.

with the Meryland

deeth

Examiner Physician/Medical 80 980 0 A Completed Be

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Certification:

physician end s the buriel-trent certificate be exec signed by the e director, this unerel After or Attending death. after death Director: filled in by 24 hours a Funeral D

Medical completely To the Vithin 2 vet

State

Registrar

31. Dete filed (Month, Day, Year) SEP 0 1 1998

25. Was case referred to medical exampler?
1 ✓ Yes 2 ☐ No

5 Pending

Investigation

6 Could not be determined

27. Manner of Death

2 Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

1 Naturel

28a. Dete of Injury (Month, Dey Year)

28c. Injury et Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, and que to the ceuse(s) and manner. On the basis of examination and/or investigetion, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

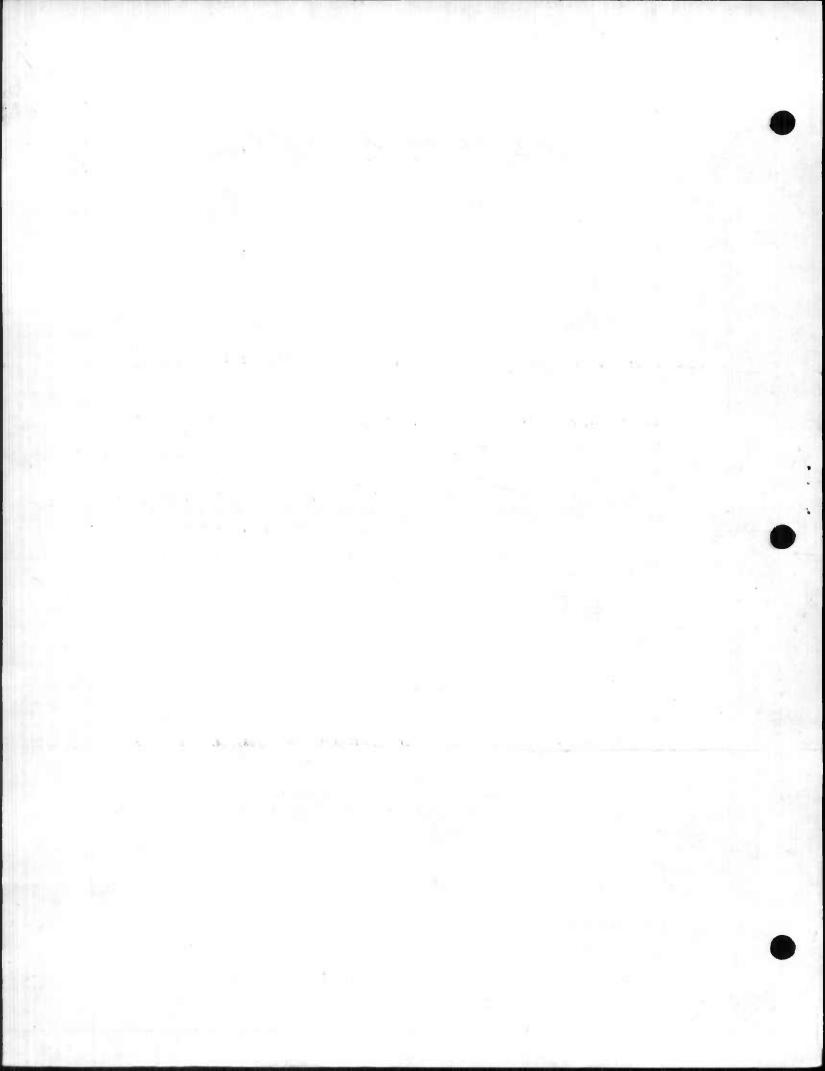
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28h Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

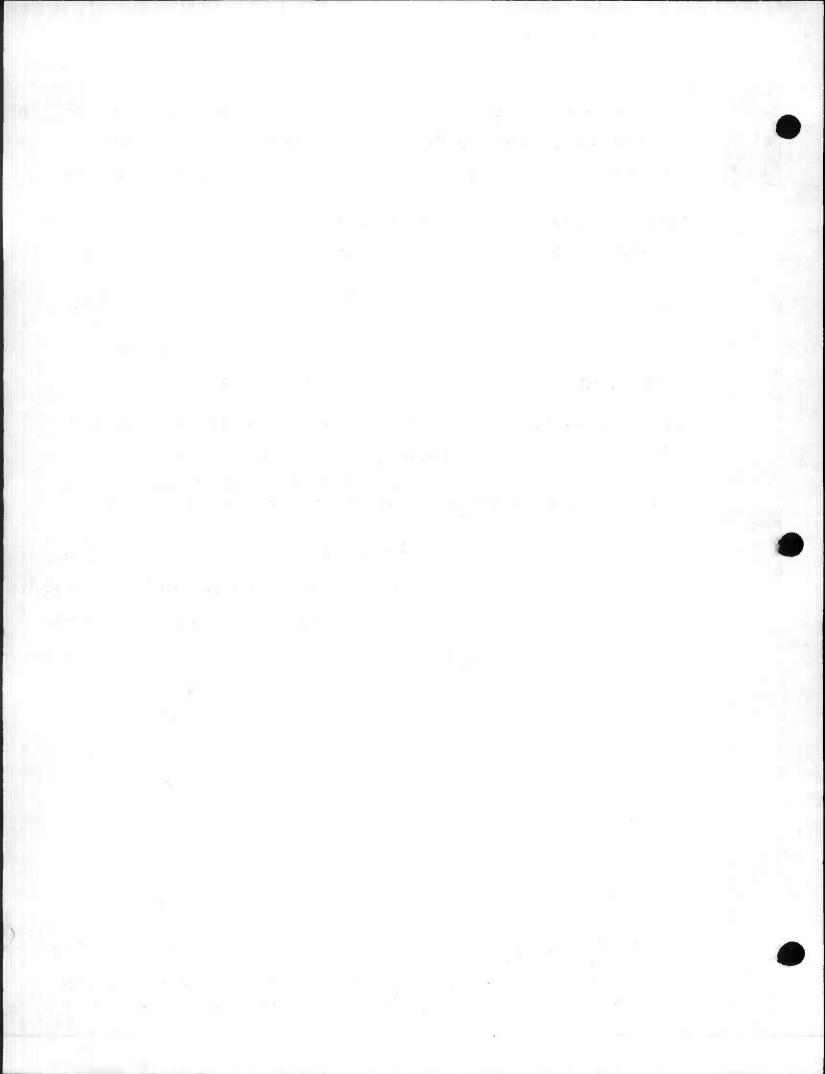
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Second Security Number   0. San						Cer	tificate of	Death	Jan. 15	Reg. No.				
Social Sciency Number   S. Dax   S. Dax	sician	pedent's Neme (F	īrst, Middle, La:	st)			YEU	ING		1 Day / /	3. Time of Deeth 7:33 Am			
10. State   100. Corety   10c. Cety from or Location   10d. Evado City Lim   11   10c. Top Code   20   10d. Cast Le Rock Drive   10d. State cet and Number   10d. Evado Cast Le Rock Drive	al 5.500	2-44-601	20 7/ per 6. S 2	Mrys x	ge (In yrs.			Clip/to	8. Date of Bi	Brike av. Year)	9. Birthplace (State or Foreign Country)			
MD   Prince Georges   Clinton   10/24   20/35   100   Caizen of What Country?   110   Mark Marine   20/35   China   12/30   Marine					10c. Cit	y, Town or Loc	ation				10d. Inside City Limits			
The composition of the composi	tor	MD P	rince G	eorges	Cli	nton					1 ☐ Yes 2 💢 No			
1. Mercial Status   1. M	10e. S			-01800			10f. Zip Code			10g. Citizen of W	hat Country?			
Separation   Sep		406 Cast	le Rock	Drive			20735	5		China				
15. Deceder(s bluster)   16. Nicro of Business/Industry   17. Father's Name (First, Mickle, Matter)   18. Mather's Name (First, Mickle, Matter)   18. Matter (First, Mickle, Matter)   18. Matter)   18. Matter (First, Mickle, Matter)   18. Matter (First, Mickle, Matter)   18. Matter (First, Mickle, Matter)   18. Matter)   18. Matter (First, Mickle, Matter)   18.		☐ Never Merried	100	Armed Forces  1 ☐ Yes 2 ☑  If Yes, Give	?				Specify Yes or No rto Rican, etc.)		k, White, etc.			
18. Mother's Name (First, Micdie, Mexicon Survame)   Sha Tsing Chan   Sh	Ele	(Specify o	only highest gra	de completed)	(Give kind of work done during most of working life, DO NOT use retired)									
19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code)  Ying San Yeung / Son  20b. Marbod of Disposition  10b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code)  74.06 Castle Rock Drive, Clinton, MD 20735  20b. Marbod of Disposition  10b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code)  74.06 Castle Rock Drive, Clinton, MD 20735  20b. Marbod of Disposition  10b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code)  74.06 Castle Rock Drive, Clinton, MD 20735  20b. Location - City or Town, State  20b. Deate of Disposition Of Part In Part In Indiana Address of Facility  Advent Funeral Even Control Internation or Complete Internation o	17. Ft								me (First, Middle					
196. Indicrement's Nemen/Reletionship (Type, Print)   196. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Ze Code)   Ying San Yeung   Son   7406 Castle Rock Drive, Clinton, MD 20735   208. Method of Disposition   Detail of Disposition   100 per 200 (Location - Chy or Town, State 4   Donation   50   100 per 200 (Location - Chy or Town, State 4   100 per 200 (Location - Chy or Town, State 4   100 per 200 (Location - Chy or Town, State 4   100 per 200 (Location - Chy or Town, State 4   100 per 200 (Location - Chy or Town, State - 200 per 200 (Location - Chy or Town, State - 200 per 200 (Location - Chy or Town, State - 200 per 200 (Location - Chy or Town, State - 200 per 200 (Location - Chy or Town, State - 200 per 200 (Location - Chy or Town, State - 200 per 200 (Location - Chy or Town, State - 200 per 2	Ď l	Shui Nan Yeung Shao							Tsing Ch	nan				
20c. Headed of Disposition   100cm				Type, Print)		19b. Meiling	Address (Stree	et and Number or F	Rural Route Numb	er, City or Town,	State, Zip Code)			
National Memorial Park   9/2/98   Falls Church, VA				/ Son	Ina. m			Rock Driv						
21. Signeture of Funeral Service Licensee  22. Name and Address of Facility Advent Funeral & Cremation Services 7211 Lee Highway, Falls Church, VA 22046  23a. Perti. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, inherived Between forset and Death Immediate Cause (Finet disease or condition resulting in death)  25a. Due to (or as a consequence of):  25a. Was case referred to medical assaminer?  1   Yes   2   No   3   Probably   24b. Were audopsy linding sveilable prot or or death)   1   Yes   2   No   2   No   1   Yes   2   No   2   No   1   Yes   2   No   No	1	XXBurial 2 □C	remetion 3 🗆		0	emetery, crem	atory or other pl							
Advent Funeral & Cremation Services 7211 Lee Highway, Falls Church, VA 22046  23a. Pertl. Enter the disease in for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate interest Services Chreat area or conditions or conditions resulting in death)  B. Due to (or as a consequence of):  24a. Was an autopsy performed?  Due to (or as a consequence of):  25. Was case referred to medical axaminer?  1   Yes   Zhor    25. Was case referred to medical axaminer?  1   Yes   Zhor    26a. Date of Injury   Zea. Date of Injury of Inj			A		Na				9/2/98	Falls Ch	urch, VA			
Immediate Cause (Finet disease or conditions as a limited for the cause of consequence of):    Due to (or es a consequence of):	)	Advent Funeral & Cremation Services 7211 Lee Highway, Falls Church, VA 22046												
24a. Wes an autopsy performed?  24a. Wes an autopsy performed?  24b. Were eutopsy linding available prior to completion of cause of death?  25. Was case referred to medicat axaminer?  1   Yes   2   No   No   Yes	Sequence Sequence Cause Cause that in result	entially list condition, leading to immede. Enter Underlying to (Disease or Injurnitated events	ons, diate kg	b	Due to (o	er es a consequ	uence of):							
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24a. Wes an autopsy performed?  24b. Were autopsy Inding available prior to completion of cause of death?  1	Part II	art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							- 1111	23b. Did tobacco use contribute to the cause of death'  1 Yes 2 No 3 Probably Unknow				
25. Was case referred to medical axaminer?    Yes   2   No									24a. Wes	s an autopsy orned?	24b. Were eutopsy lindings aveilable prior to completion of cause of death?			
axaminer?	5					Marie I	. 72		10	Yes ZXNo	1 ☐ Yes 2 ☐ No			
27. Manner of Death   1	a ax	kaminer?	to medicat	Hospital:			-510	Whor						
29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)		anner of Death		28a. Date of Inj (Month, Di		28b. Time of	28c. Inj	ury at ork?	7-					
29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	3			288. Place of in	jury - At ho lc. (Specif	ome, larm, stre	et, fectory, office	9	28f. Location City or To	281. Location (Street and Number or Rural Route Number, City or Town, Stele)				
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)		(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)												
	294.	une)									(Month, Day, Year)			



State of Maryland / Department of Health and Mental Hygiene 98

					Cer	tificate of	Death		Reg. No.	0 4	0330		
Physician		1. Decedent's Neme (First, Middle, Li						2. Dete of Dee		Yeer	3. Time of Deeth		
/Medical	_	EVELYN	L YOS	7				AVG		1998	12:0381		
Examiner	r	4e. Fecility Name (If not institution, gi					4b. City, Town, or	Location of Deeth	4c. Count	ty of Deeth			
		Howard Count		-		With the dist	Columb			loward			
Funeral Director		213-74-6430 Usual Residence of Decedent	1□M 2⊠F	(In yrs. lest i	Yrs.	If Under 1 Year Months Deys			r, Year)	Counti	ece (Stete or Foreign ry) yland		
death with the Maryland ms 23a or 28a-f show r.must be notified at meral Director	_	10a. State 10b. County		10c. City, To						10	Od. Inside City Limits		
Sa-f	2	Maryland Howar	d	El	licot	t City			1 Tes				
r items 23a or 28a-f solorer must be notified	9	10e. Street end Number 9749 Riverside Ci	rcle			10f. Zip Code 210	42		10g. Citizen of Unite	Whet Count A Stat	•		
al', or its	2	11. Marital Status  1 □ Never Merried 2 □ Married  3 ₺ Widowed 4 □ Divorced	12. Wes Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates:			as Decedent of Nes, specify Cub	Hispenic Origin? (5 en, Mexicen, Puer Specify:	Specify Yes or No- to Rican, etc.)		R. Race - Americen Indian, Bleck, White, etc. Specify: White			
ygiene. ser than "natural", rt, the Medical Exp Completed by	2010	15. Decedent's E (Specify only highest gr	ducation ade completed)	16	Se. Decede	ent's Usuel Occup	petion during most of wa	rkina	16b. Kind of I	3usiness/Indi	ustry		
than the Me	2	Elementary/Secondery (0-12)	College (1-4or 5+	)			during most of wo						
Hygier other th		6			Hon	maker				Home			
Mental rrked c atic sv	0	17. Fether's Neme (First, Middle, Last Charles Bucheimer						me (First, Middle, n Renoff	Meiden Suma	me)			
a me		19a. Informant's Name/Relationship	Type, Print)	15	9b. Mailing	Address (Street	t end Number or R	ural Route Numbe	r, City or Town	n, State, Zip (	Code)		
am 27 ther tr		Lloyd S. Yost Jr.	/Son		4414	Cross Co	ountry Dr	rive Elli	cott C	ity, M	D 21042		
r of H		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Domoval from State			ition (Neme of atory or other ple	ice)	Dete	20c. Location	- City or Tow	vn, Stete		
ant: If its ury or of		4 □ Donetion 5 □ Other (Special		Wood.	lawn	Cemeter	У	9-2-98	-98 Woodlawn, MD				
Department of Health Important: if item 27 any injury or other trong once.		21. Signeture of Funeral Service Lice	nsee	- 0 -	22. Ha	Name end Addre	ess of Facility Witzke's	Family I	uneral	Home,	Inc.		
	+	23a. Pert1. Enter the disease, or com shock, or heart feilure. List only	plicetions that caused the	he death. D	o not ente	the mode of dvl	ng, such es cardia	PIKE EII	lcott		MD 21043 Approximate		
ysician	1	shock, or heart feilure. List only	one cause on each line					, , , , , , , , , , , , , , , , , , , ,			Intervet Between Onset end Death		
ledical		Immediate Cause (Final			A.	6TZY2	) =				1 100		
miner	1	disease or condition resulting in death)	ө				20				1 MK		
ner ner			b	ue to (or es		YOCAP	DIA	INPAR	CTION	į	2-15-15		
n end iel-transit Examiner		Sequentially list conditions.	b	ue to (or es			-14		110.4		2013		
uniel-l		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury					TIVE	INPAR	RE		ZWZS.		
e es the buriel-transit		thet initiated events resulting In deeth) Lest	Di Di	ue to (or es		ence of):	A			1			
		·	d	FORT	īc	51	ENOSI	S	2WK				
ed by the ettend detached for us repaired for us		Pert ii. Other significent conditions of	ontributing to death but	not resulting	ng In the underlying ceuse given in Pert I. 23b. I				D. Did tobacco use contribute to the cause of				
Phy t								101	Yes 2 No 3 Probably 4 Unknown				
5 2													
shoul								24e. Wes e perfor		com	re eutopsy findings lleble prior to apletion of ceuse eeth?		
page 2								1 U Y	es 20No	11.00	Yes 2□ No		
rector, pag	E .	25. Was cese referred to medicel					26 Place of Do	eth (Check only or			160 2010		
	1	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient	2 DEPV	\tnationt	3□ DOA Oth	nor:						
두 등		27. Manner of Death	28a. Date of Injury	28b	. Time of	28c. Injui		fome 5 ☐ Resid			,		
e fun		1 Natural 5 ☐ Pending 2 ☐ Accident Investigatio	(Month, Dey 1	Y99r)	Injury		rk? ∣Yes 2 □ No						
al Director: After ted in by the funers Certification:		3 Suicide 6 Could not be determined	0 00 50 00 00					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
S I I I										-			
To the Funaral Dir completely filled in Medical Cert		29a. Certifier (Check only one)  Check only 2 Medical Example (Check only one)	ge, death o end/or Inve	estigation, in my o	me, dete end place opinion, death occu	, and due to the c irred at the time, c	to the ceuse(s) end manner as steted. e time, date end place, end due to the ceuse(s)						
To the comple		29b. Signature end title of certifier				29c. Licens		2	9d. Dete sign				
		Into He	Leus			12	8921		AUGI.	30.	1998.		
)		30. Name end eddress of person who	completed cause of dee	oth (Item 23e	) (Type, P	rint) LU 7	92 It	CHIRL	Lina	- R	onn		
State		31. Dete filed (Month, Day, Year)	32. Registrar	s Signature	7 '		(n.	1.1 most	mo	10111			
Registrar		SEP 0 1 199	₩	na	4	1		A MINING	79 2	1044	f 1		

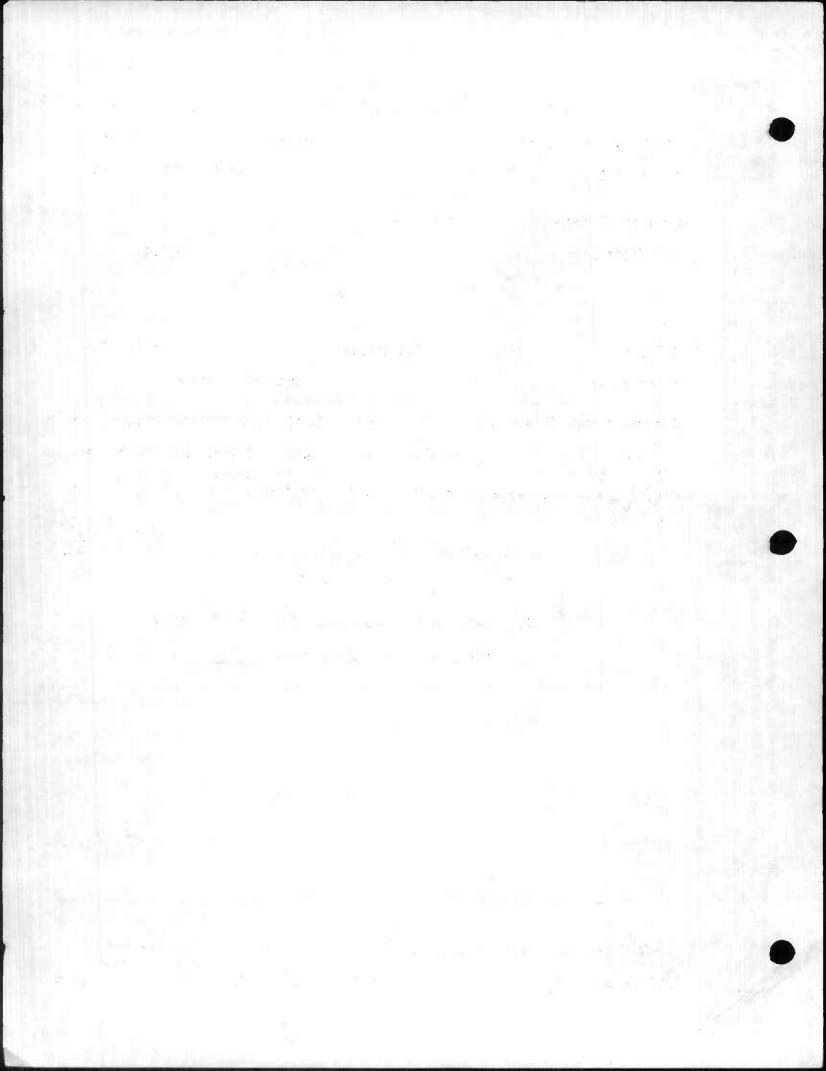


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene REPLACEMENT Items: 28-a,b,c,e,d per MEO G-763 9/24/98 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dev **Physician** Tombar 6.1998 921 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** Parkville Baltimore Oak Crest Care Center If Under 24 Hrs. Hours Min. If Under 1 Yeer Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) 6. Sex **Funeral** Davs Months 1 M 2 V F Yrs. Director 92 08-29-1906 Italy 215-12-9610 tha Meryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Salisbury Maryland | Wicomico 10f. Zip Code 10e. Street end Number 10g, Citizen of Whet Country? daeth with U.S.A. 21804 906 James Court Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status hours efter 1 Never Merried 2 Merried White altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 permit. Pages 1 and 2 should be filed within; Department of Haalth and Mental Hygiene. Important: If item 27 ia marked other than "n any injury or other treumatic event, the Medipage. filed within Elementery/Secondery (0-12) College (1-4or 5+) N/A Tailor Shop 6 Years Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Catherine Iofrida Bruno Alvaro 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21030 4 Timberwood Court Cockysville, Maryland Frances Alvaro (Daughter) 20b. Plece of Disposition (Name of cometery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 9-9-98 Baltimore, Maryland Moreland Memorial Park Other (Specify) 22. Name end Address of Fecility Leonard J. Ruck, Inc. 21 516 nature of Funeral Service Licensee 5305 Harford Road Baltimore, Maryland 21214 J. Wayne Osterling dispase, or complications thet caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory errest, feilule. List only one cause on each line. Approximate Interval Between Description Death Physician /Medical Immediate Cause (Pinel disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner -2 INP and I-transit cartificate be executed Sequentially list conditions, if eny, teeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Lest physician at stha buriel-t errose/es Box 68760 olic Physician/Medical Due to (or es e consequence of) for usa as 88 9 3 SLESL The law requires that the deeth signed by tha eld be deteched for P.O. Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records. p been sign 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? is certificata has t director, paga 2 s 2. No 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completaly filled in by the funeral director, to Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) examiner2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Date of tnjury (Month, Day Year) 27. Menner of Deeth 28b. Time of Injury 28c. Injury et Work? Certification: 28d. Describe how Injury occurred 5 Pending investigation 1 Netural Bedroom 1 ☐ Yes 8/26/98 12/ 2 Accident Unk. 12 281. Location (Street and Number or Aural Route Number, City or Town, State) Walther Blvd. Parkville, Md. 21236 3 Suicide 6 Could not be determined 28e. Ptece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide at Home 1 Capitying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture and titis of certifier 29c. License number 30. Name end eddgess of person who completed cause of death (Item 23e) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** EORGIANNA 4c. County of Death /Medical 4b. City, Town, or Location of D Fecility Name (If not institution, give street end number) Examiner 4339 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign Country) Age (In yrs. lest birthday) 6. Sex **Funeral** Deys Min Months Hours 1 M 2 4 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental hygiene. Important: If Item 27 is marked other than "natural", or Item 23a or 28a-f show any Injury or other traumetic event, to Medical Exaternal main be notified. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 2 Yes 2 No Director end Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral Wes Decedent Ever In U.S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Detes: American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece -Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ NO Specify. LOCK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) pdary (0-12) College (1-4or 5+) Father's Neme (First, Middle, Last) Mother's Neme (First, Middle, Maide Be oulse Address (Street end Number or Rural Route REISTERS TIWN R 21215 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremation 5 Other (Specify) 4 Donetion TAS se or complications that ceused the deeth. Do not enter List only one ceuse on each line. Approximate Intervel Between Onset end Deeth disease Teilure. **Physician** /Medical Immediate Cause (Fine Metastatic Small Cell concer to brain diseese or condition resulting in death) Examiner Due to (or as a consequence of): of unknown primary Examiner The law requires that the death certificate be executed ettending physician end for use es the buriel-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. the 1 Nes 2 No 3 3 Probably 4 Unknown signed b ò 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed peen s certificete has 1 Tyes 2 1 No 1 ☐ Yes 2 ☐ No or Attending Physician: director, Be 25. Was case referred to medicel examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this of in by the funeral 27. Mennes of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 28e. Date of Injury (Month, Dev Year) 1 Naturel 5 Pending Injury 1 Tyes 2 No death. 2 Accident investigation 6 ☐ Could not be 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as stated. 29e. Certifier Medical (Check only 2 Medical Examiner: On the besis of exeminetion end/or investigation, In my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. one) 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number

State Registrar 30. Nem and eddress of corson who completed cause of death (Item 23a) (Type, Print)

Fern Jeffrie, MD

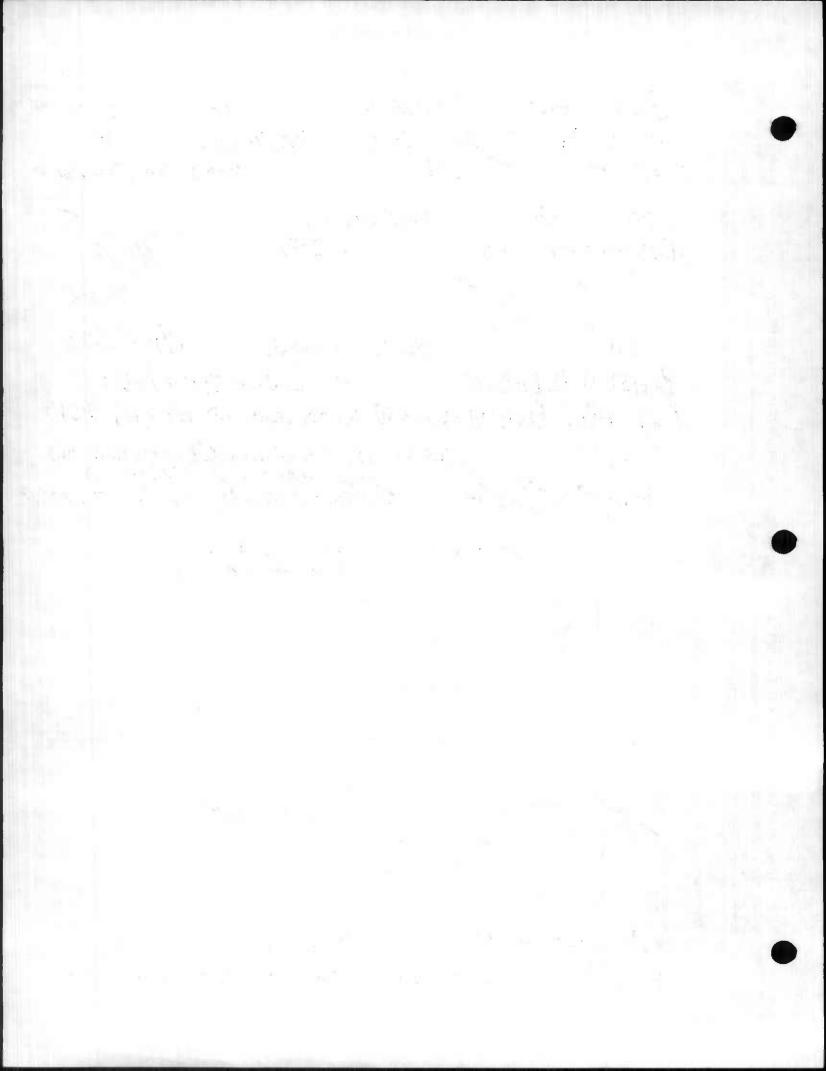
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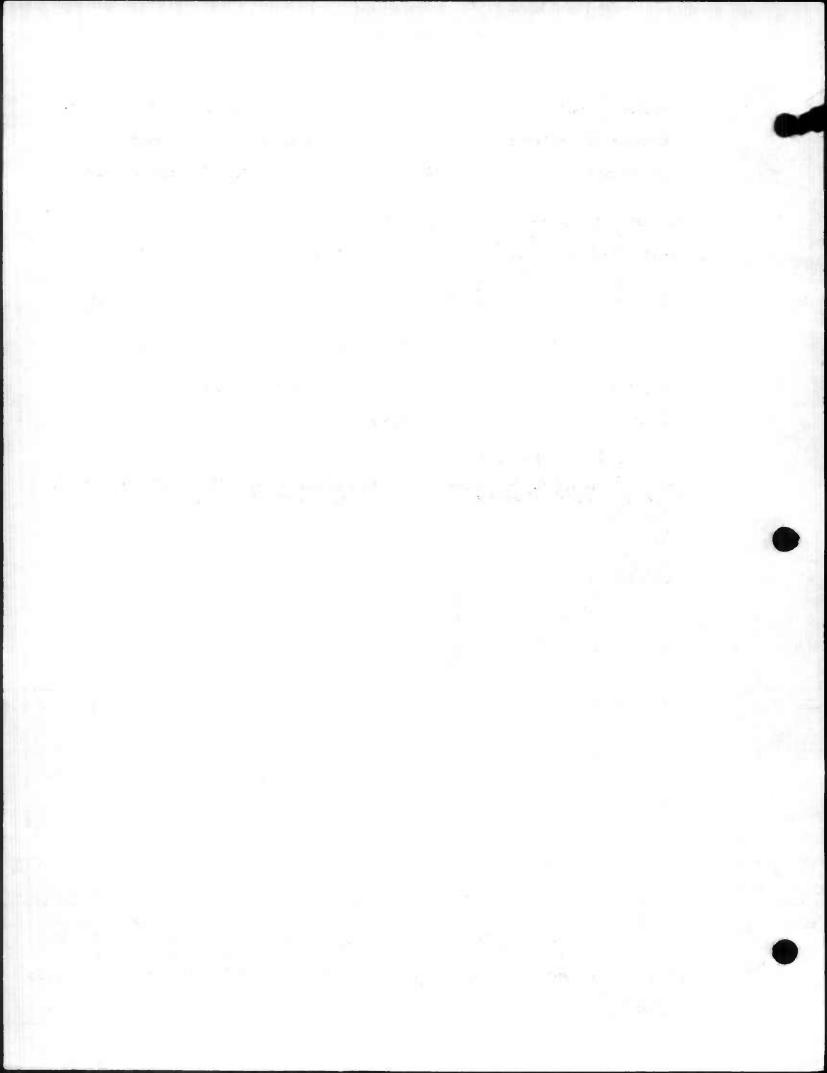
32. Registrar's Signature

Avenu #22, Baltman, MD



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1006 J. ML 052881 8/23/98	P		29b. Signature and title of certifiar				25	c. Licans	e number		29d. l	Date signed	(Month, E	ay/Year)	
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedant's Name (First, Middla, Last) 2. Data of Death **Physician** Month sowers 0 /Medical 4a. Facility Name (If not institution, 4b. City, Town, or Location of Death give straat and numbar) Examiner 4c. County of Death Galtimore Undar 24 Hrs. 8. Data of Birt on 7. Aga (In yrs. If Undar 1 5. Social Sacurity Number 6. Sax last birthday) 8. Data of Birth **Funeral** 214-24-9008 Usual Rasidance of Dacedant Months 1 M 2 F Days Hours Min Director is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentel Hygiene. Item 27 is merked other than "natural", or items 23a or 28a-f show other treumstic event, its Medical Example manual constituted. 10c. City, Town or Location 10d. tnsida City Llmits Maryland Director 1 XYas 2 No more 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 22 2 21 onroe Funeral 12. Was Decedant Evar In U,S. Armad Forcas? 11. Marital Status Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race -Amarican Indian Black, Whita, atc. 1 Naver Married 2 Marriad ☐Yas 2XNo Yes, Give 1 Yas 2 No Spacify: by 3X Widowed 4 ☐ Divorced Slac Year or Datas: Completed 16a. Dacedent's Usual Occupation (Give kind of work dona during most of working life, DO NOT usa ratired) 15. Dacedant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elamantany/Secondary (0-12) College (1-4or 5+) omemaker tome Baltimore, Maryland 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be ames 0 nomas Pages 1 end 2 should 19a. Informant's Name/Ralationship (Typa, Print) (niece) 19b. Mailing Address (Streat and Numbar or Rural Routa Number, City or Town 5220 urner Yor to. 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of Date 20c. Location - City or Town, Stata permit. Pages Dapertment of H Important: If its any Injury or ot otice. ryatery, cramatory or other place) 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 Donation 5 Dothar (Specify) ansdowne -10n 22. Nama and Addrass of Facility Nra of Funaral Sarvice/Licensan Josep 2222 er W. North Ave 1 to. 1419 the displace, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, and fair a. List only one cause on each line. Approximata Intarval Batween Onset and Daeth **Physician** /Medicai Immedieta Causa (Finel disaasa or condition rasulting in death) Bronchomeumoma **Examiner** Duff to (or as e consequence of): Physician/Medical Examiner ind-Stag Domergia the attending physicien end thed for usa as the buriel-transit Tha law requires that the daath certificete be executed Sequantielly list conditions, if any, laading to immadiata ceuse. Enter Undarlying Ceusa (Disaase or injury that initiated evants Neurologic Degenerative Disorder of uncertain etrology P.O. Box 68760, Due to (or as a consequence of) rasulting In daath) Last Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Pressurencers Records, þ 24b. Wara autopsy findings available prior to complation of causa of death? Completed 24a. Was an autopsy performed? theyo enfancous Hap sur peen certificate has 2 No 1 ☐ Yas 2 ☐ No Be 25. Was cesa rafarrad to medicat 26. Place of Deeth (Check only one) 10 Hospital: Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Data of tnjury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? edicai Certification: 28b. Tima of 28d. Dascribe how Injury occurred Isibn Bill 5 Panding investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be datarmined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida

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State Registrar

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29a. Cartifiar (Check only one)

29b. Signatura and titia of certifiar

George rater, My 31. Data filed (Month, Day, Year)

171998 SEP

30. Nama and eddress of person who completed ceuse of death (Itam 23a) (Type, Print)

6// South 32. Registrar's Signatura

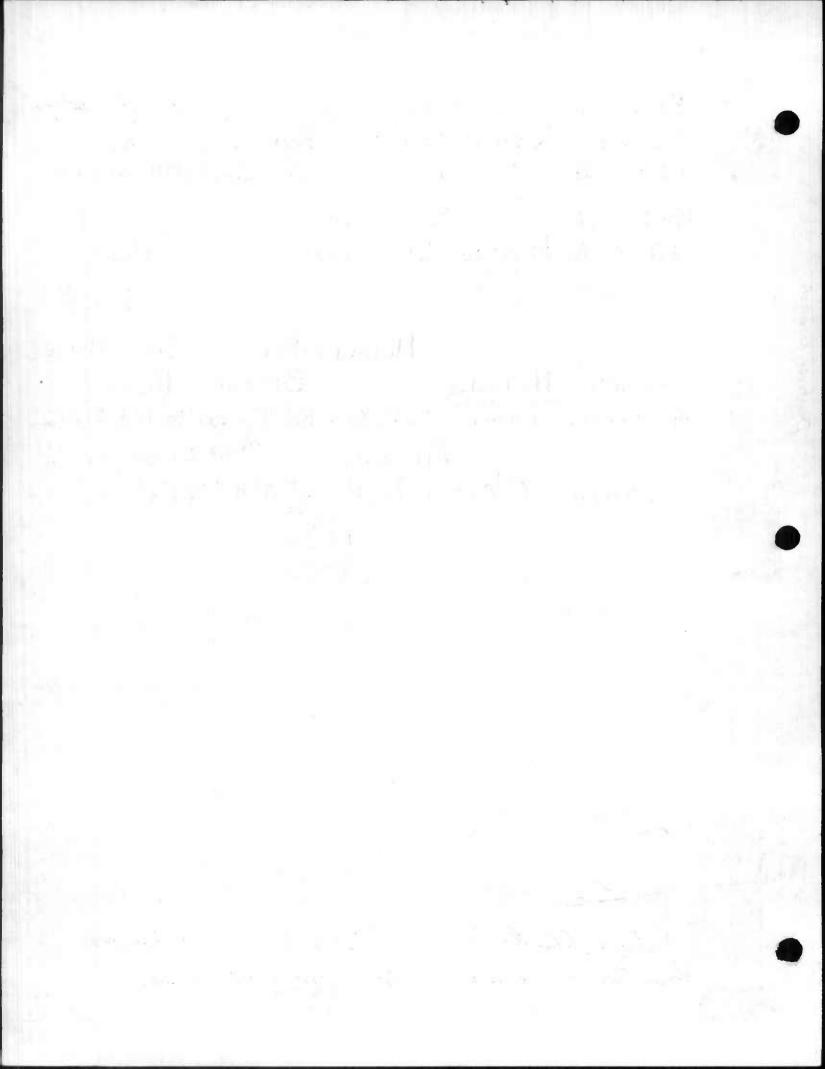
Charkest pet Bathroom, Mel - 21230

1 Certifying Physician: To tha best of my knowledga, death occurred at tha tima, data and place, and dua to tha cause(s) end mannar as stated.
2 Madicat Examiner: On the bests of axamination and/or invastigation, in my opinion, daath occurred at the tima, data and place, and dua to the cause(s) and mannar stated.

29c. License number

29d. Data signed (Month, Day, Yaar)

15,1998



#### Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death ent's Name (First, Middle, Las) 1230 Month **Physician** anco IAM /Medical 4b. City, Town or Location of Deeth 4c. County of Death, Examiner 7. Age (In yrs. last birthday) Yrs. 8. Date of Birth (Month, Dey, If Under 1 Year 9. Birthplace (State or Foreign Country) If Under 24 Hrs **Funeral** 10M 20F Months Days Hours Director the Maryland 10a. Stete 10c. City. Town or Location 10d. Inside City Limits 10b. County 28a-f ahow the Medical Examiner must be notified at Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Herns 23a or Funeral Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married ò 1□ Yes 20 No Black altimore. Maryland 21215-0020 Specify Specify: P 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural", Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) ith and Mental F. Be permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If Item 27 is marked of - walne prace pracco aura 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Road Balto. 4021207 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Louise Bracco will Wentworth 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 0 Baltinoie NO 4 ☐ Donation 5 ☐ Other (Specify) any Injury and Ac 21. Signature of Funeral Service License Gilhor the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, 236 Part). Enter the disease, o Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final arcinoma disease or condition resulting in deeth) Examiner Due to (or es a consequenca of) Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as e consequenca of) Physiclan/Medical Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 3 Division of Vital Records, P.O. 12 108 2 No 3 ☐ Probably 4 ☐ Unknown B by 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 Yes 2 No 1 Yes 2 No certific Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 결 28a. Date of injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of Certification: Ather 5 Pending investigation Injury 1 Natural after death. 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide ò 24 hours a Funeral C 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the ceuse(s) and menner stated. To the To The To the F 29d. Date signed (Month, Dev. Year) 29b. Signature and title of cartifier 29c. License number vam MA

State Registrar

31. Date filed (Month, Dey, Year) 32. Registrar's Signeture 7

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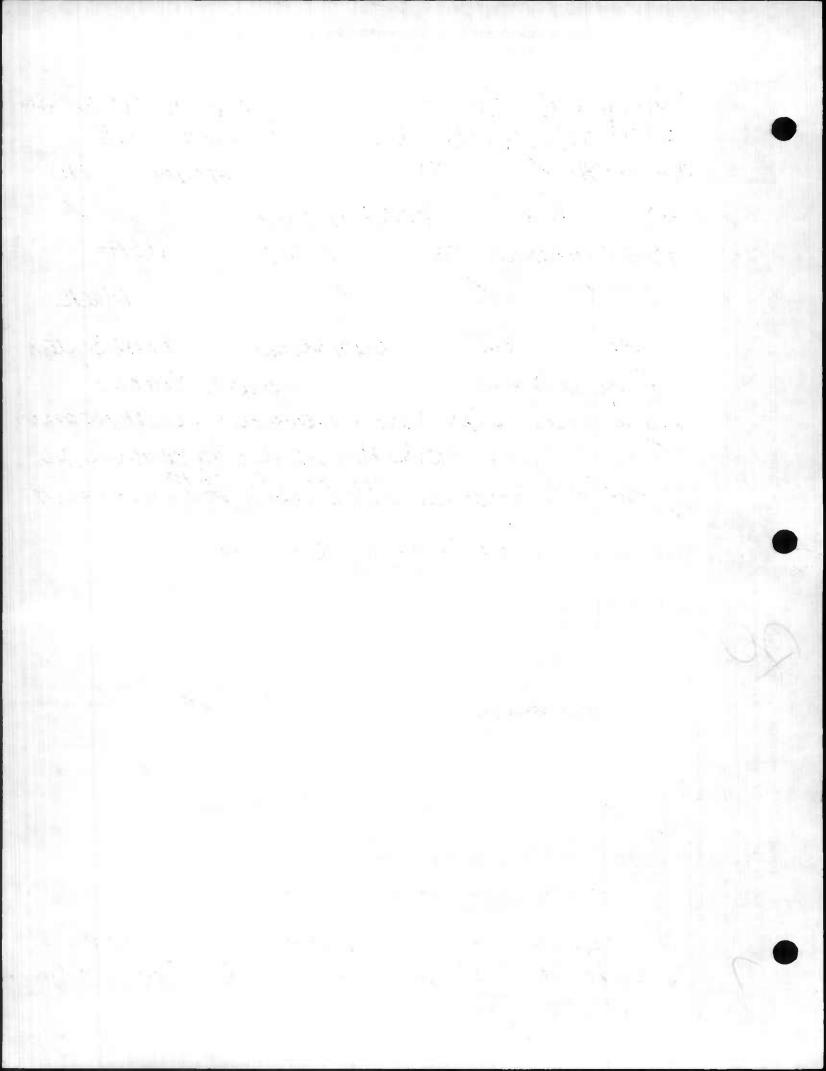
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

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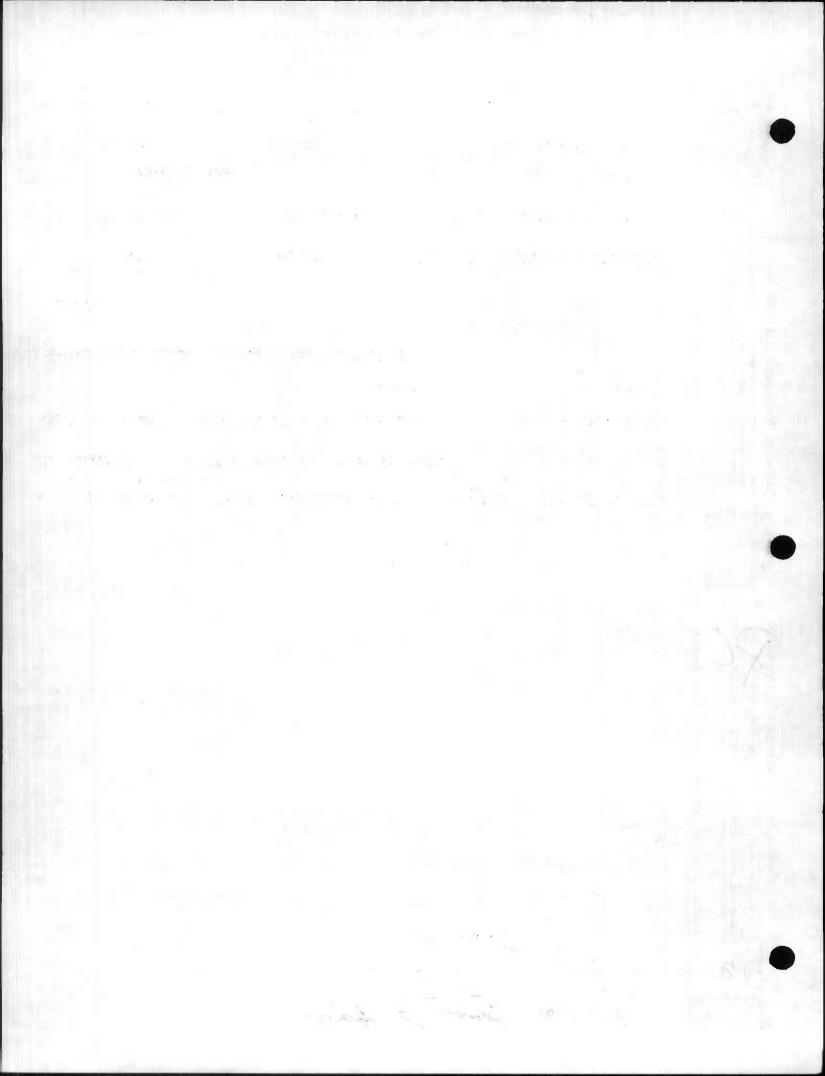
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'ud, Baltimore



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** SEPT. 12, 1998 2:33 PM HENRY BIANCHI /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner OLD COURT NURSING HOME BALTIMORE If Under 1 Year 8. Date of Birth (Month, Day, Year) SEPT. 3, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2□ F Months Days Hours Min 94 Yrs. PA Director 215-01-8015 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show ir than "naturel", or items 23a or 28a-f show MD BALTIMORE BALTIMORE 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 7203 ROCKLAND HILLS DRIVE 21209 U.S.A. #511 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Raca - American Indien Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3√ Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Depertment of Health end Mental Hygiene. Important: If item 27 Ie marked other than eny injury or other treumatic event, the Ma College (1-4or 5+) Elementery/Secondary (0-12) MAINTENANCE COORDINATOR NORTHWEST HOSPITAL CTR 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) BIANCHI **JOHN** FRIEDA KUBAK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7203 ROCKLAND HILLS DR. #511 BALTIMORE, MD 21209 BRYNA ROODY / NIECE 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State REISTERSTOWN, MD 4 ☐ Donetion 5 ☐ Other (Specify) BALTIMORE HEBREW CEMETERY 9/13/98 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Juneral Servica Licansee any le 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of) Due to (or es e consequenca of): Box 23b. Did tobecco use contribute to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 94 1 Yes 2 No 3 Probably 4 Unknown 3 à The law requires 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peed hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) funeral 27. Manner of Deeth 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After 5 Pending investigation or Attending 1 Naturel 1 Yes 2 No death. Director: A 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) efter 4 Homicide 24 hours 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated edicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) end manner stated. (Check only one) within 2 29b. Signeture end till of certil 29c. License number 29d. Date signed (Month, Day, Year) HOWARD GARBER 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 310 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State 5 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day 1998 **Physician** August 10, Geraldine Frances Beiser 6:30 P.M. /Medical 4b. City, Town, or Location of Deeth 4e. Facility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** Shady Grove Adventist Hospital Rockville Montgomery County If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthpiece (State or Foreign Country) **Funeral** 1□ M 2Ĭ F 496-07-7146 78 Yrs. October 4, Director 1919 Missouri Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at Montgomery Maryland Germantown 1 ☐ Yes 2 🕱 No Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? United States with 11238 Minstrel Tune Drive 20876 238 permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural; or items 29a any injury or other traumatic event, the Medical Examinar manager other. Funeral of America 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No þ Specify: White 3℃ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry California Highway Patrol Elementery/Secondery (0-12) College (1-4or 5+) Crossing Guard (Law Enforcement) 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Leo Hart Frances Halbaur 2 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 20876 19e. Informent's Neme/Reletionship (Type, Print) Linda Novitzki- Daughter 11238 Minstrel Tune Drive, Germantown, Maryland 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete August Whitter, 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Rose Hills Memorial Park 14, 1998 California 22. Name end Address of Fecility Rose Hills Mortuary 3888 South Workman Mill Road, Whitter, CA 90601 artt. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, book, or high failure. List only one cause on each line. Approximete interval Betw Onset end Death **Physician** Immediate Cause (Fine) disease or condition resulting in death) /Medical Examiner Examiner unial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last and Division of Vital Records, P.O. Box 68780 8 Physician/Medical Due to (or es e consequence of): The law requires that the death certain signed by the atte Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to Completed completion of cause of death? has 1 ☐ Yes 2 No 1 ☐ Yes 2 No certificate or Attending Physician: Be 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28e. Dete of tnjury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: After 5 Pending 1 Neturel death. investigation 1 Yes 2 No 2 Accident after death Director: 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral D completely filled i edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end menner es stated. (Check only one) 2 Medical Examiner: On the basis of exeminetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) September 16, 1998 30. Name and eddress of person who completed cause of death (item 23e) (Type, Print) 481 North Frederick Ave. #230, Gaithersburg, MD 20879 Suhair H. Abulfarag, MD 31. Dete filed (Month, Dey, Year) SEP 1 7 1998

32. Registrer's Signeture

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**DHMH 16 Rev 6/95** 

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Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Deeth Physician 14th Sept 4:50 P.M. Virginia brown /Medical 4e. Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SANDTOWN WINCHESTER NURSING HOME BALTIMORE N/A If Under 1 Year 5. Sociel Security Number If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Ye 11/12/07 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign **Funeral** Deys 1 M 2 F Months Hours Yrs. VIRGINIA Director 90 220-38-7925 Usual Residence of Decedent 10e. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show "naturel", or items 23a or 28a-f shed sai Evaminer must be notified 1 XYes 2 No Director N/A BALTIMORE MD 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1000 N. GILMORE STREET 21217 U.S. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 11. Maritel Status 14. Raca - American Indien Bleck, White, etc. 72 hours efter 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Completed by Specify: 3 XWidowed 4 ☐ Divorced BLACK th end Mental Hygiene.
7 is marked other than "natur treumetic event, the Medical 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 DOMESTIC PRIVATE FAMILY -0-Baltimore, Maryland 17. Fether's Name (First, Middle, Last) Deges 1 and 2 should be fill out of Heelth end Mental Hit: If item 27 is marked oth y or other treumatic eventy. 18. Mother's Name (First, Middle, Meiden Sumeme) Be RAYMOND COOK REBECCA BELLE 19a. Informent's Neme/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELAINE PAGE (DAUGHTER) 507 E. COLDSPRING LANE-BALTIMORE, MARYLAND 21212 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) Date 20c. Location - City or Town, Stete Peges 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Depertment of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 9/19/98 ARBUTUS, MARYLAND ARBUTUS MEMORIAL PARK 21. Signature of Funeral Service License 22. Name end Address of Fecility REDD FUNERAL SERVICE 1721-27 N. MONROE STREET-BALTIMORE, MD 21217 23a/Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** INOMA OF STOMACH /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner edical Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Physician/M Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 0 1 Yee 2 No 3 Probably 4 Winknown 0 Records. Completed by sign 24b. Were eutopsy findings aveileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? pege 2 2 NO 1 Yes 1 ☐ Yes 2 ☐ No certificate Vital Be 25. Wes cese referred to medical 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 5 Residence 6 Other (Specify) Certification: To Division of Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? i or Attending P efter death. Director: After t Naturel 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 24 hours c Hospitai Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) To the Vithin 2 To the Comple 29b. Signat use of deeth (Item 23a) (Type, Print) RABHAK RRMO, 21150LO dREMS RAGISTES 31. Date filed (Month, Dey, Year) Registrer's Signeture State SEP Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Year September 14, 1998 **Physician** Leonard M. Bauer, Sr. 5:30 AM /Medical 4e Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 1349 Cedarcroft Road If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 10-1-1916 9. Birthplaca (State or Foreign Country) Maryland **Funeral** Deys Months Hours 1√2 M 2□ F Yrs 81 Director 212-05-2702 Usual Residence of Decedent 10b Counts 10c. City, Town or Location 10d. Inside City Limits 1 □XYes 2 □ No Directo Maryland 28a-t Baltimore 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? Name 23a or 21239 U. S. A. 1349 Cedarcroft Funeral Road 12. Wes Decedent Ever in U,S. Armed Forces?

1 Dives 2 DNo WWII Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 b 1 Yes 2√ No Specify: Specify: White À 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) BGE Foreman 17. Fether's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Pages 1 and 2 should be Health and Mental is marked John Bauer Catherine Antkowiak 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Margaret A. Bauer (Wife) 1349 Cedarcroft Road, Baltimore, Maryland 21239 Important: If Item 27 any injury or other to 20b. Place of Disposition (Name of competery, crematory or other place)
Parkwood Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, Stete b 1 Buriel 2 Cremetion 3 Removel from Stete 9-17-98 Parkville, Maryland 4 □ Donetion 5 □ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility
Ruck Towson Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. 1050 York Road, Towson, Md. 21204 Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examiner EUMONIA Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or es e consequence of): CHEXIA Physician/Medical Box The law requires that the death Pert If. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 ☐ Yes 2 2 No 3 Probably 4 ☐ Unknown þ APTERIOSCIEROTIC HEART DISEASE 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 28TNo 1 Yes 1 ☐ Yes 2 ☐ No Division of Vitai or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation death. t ☐ Yes 2 ☐ No Hospital or Attend
 24 hours after death
 Funeral Director: A 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated. (Check only one) completely On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end pleca, end due to the cause(s) and menner stated. within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature

DHMH 16 Rev 6/95

State

Registrar

30. Name end address of person who completed call

1998

31. Dete filed (Month EP)

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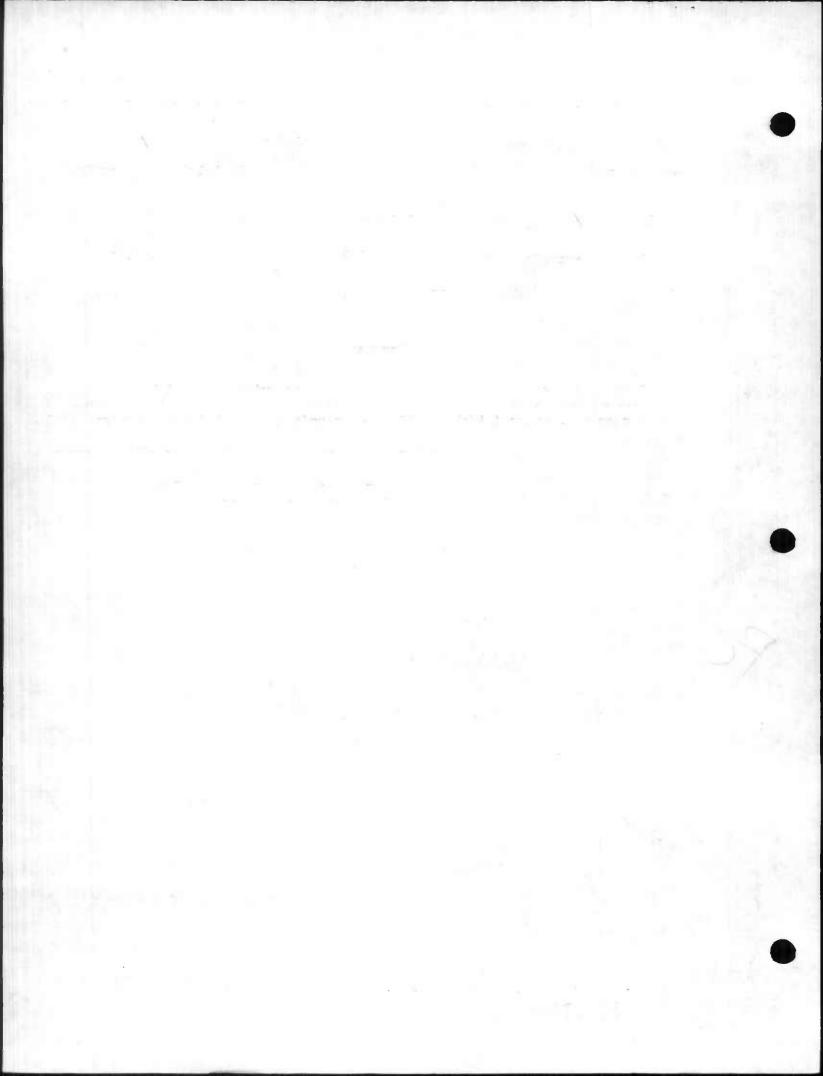
W COLD SPRING CANE BARTINER 2120

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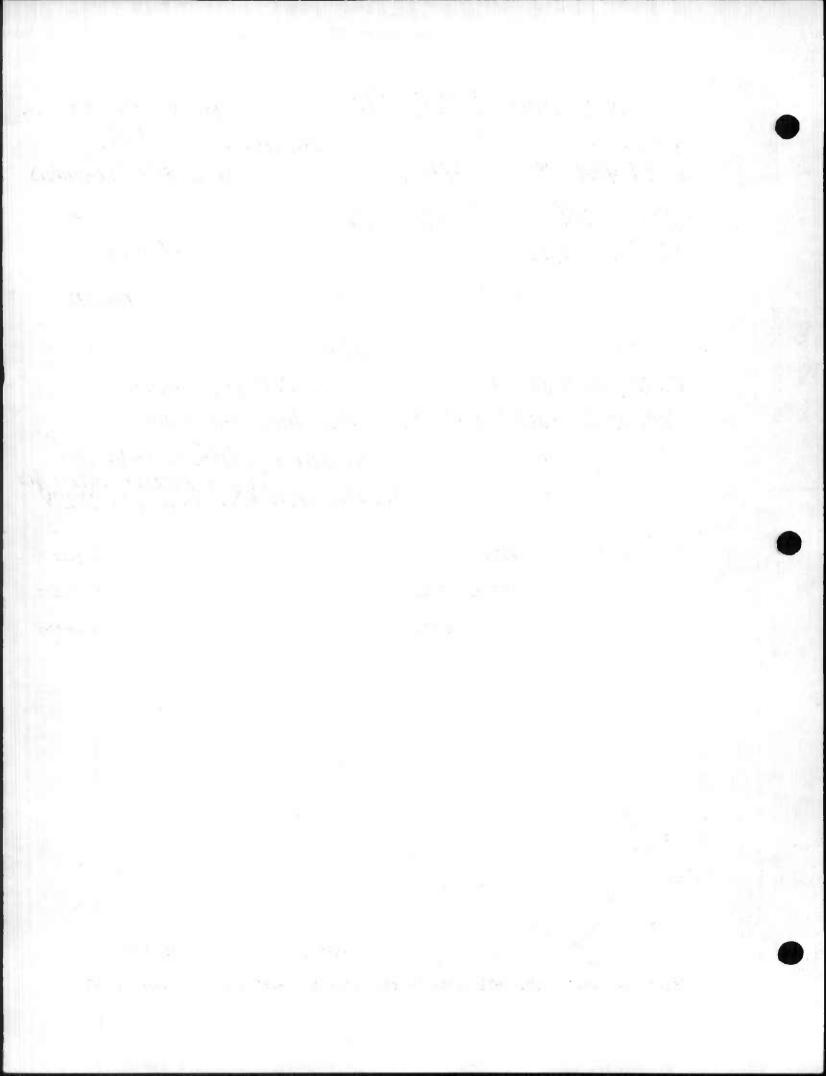
32. Registrer's Signeture



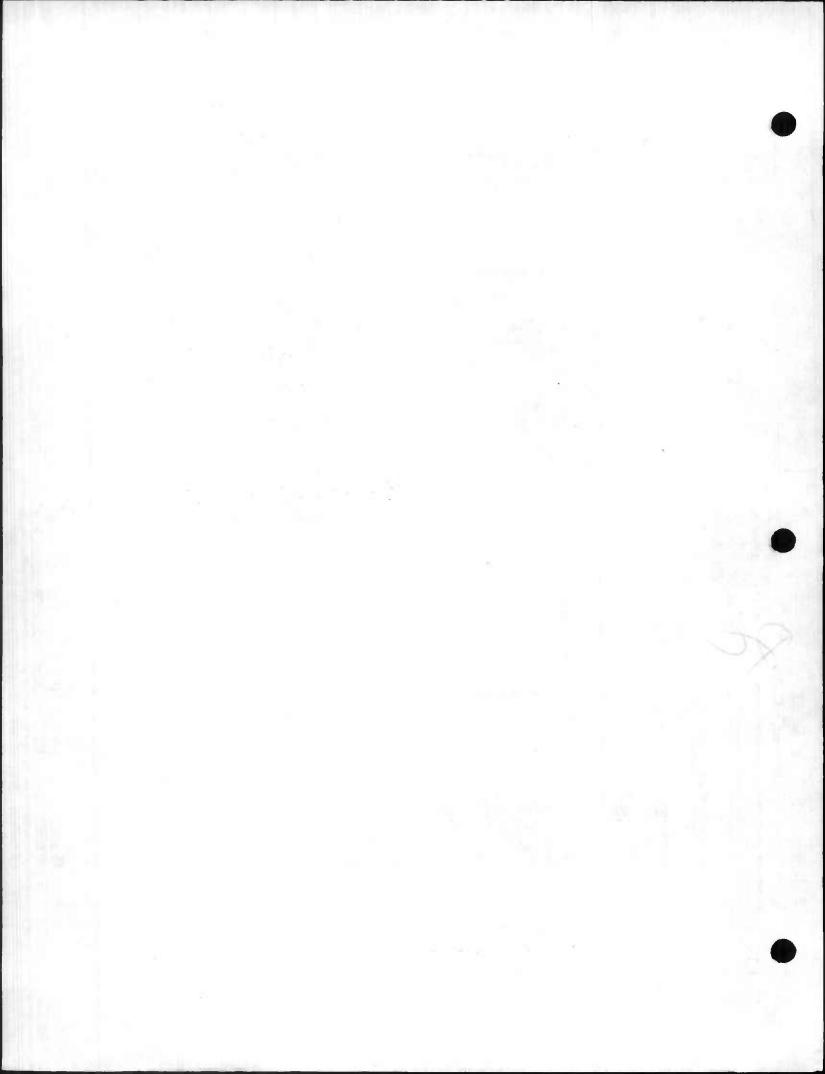
**Funera** Directo

	Physician /Medical Examiner
Division of Vital Records, P.O. Box 68760,	To the Mospital or Attending Physician: The lew requires that the death certificete be executed within 24 hours effer death.  To the Funeral Director: After this certificete has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be deteched for use es the buriel-transit.

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er	4a. Facility Nama (If not institution, g	Iva street and number)	ENL SUR	1 4b. Gity, Town	n, or Location of Daath	4c. County	of Death			
4	5 Social Security Number 6.	Sax 7. Aga (In vrs	a last birthday)	nder 1 Year If Undar 24	Hrs. 9 Date of Rid	/	O Piethofo	on /Chata on Fami		
	Usual Rasidence of Decedant	10 M 20 F	Yrs. Mon		Min. 8. Data of Birth	5,1957	9. Birthpla	Stata or Foreign		
	10a. Stata 10b. County	10c. C	ity, Town or Location				100	d. Insida City Limit		
ctor	MID IVIT	10	HITIMO	RE				1 Pras 2 □ N		
Funeral Director	3214 Blueh	ill	10f	2120°	7	10g. Citizen of V	Whet Countr	y?		
inel	11. Marital Status	12. Was Decedant Evar in I	U,S. 13. Was D	ecedent of Hispanic Origin specify Cuban, Maxican, I	n? (Specify Yas or No- Puarto Ricen, etc.)	14. Rac	e - Amarice			
by	1 Navar Marriad 2 Married 3 Widowed 4 Divorced	1 ☐ Yas 2 12 No If Yas, Giva Yaar or Dates:		es 2 No Specify:		Specify	nin	CK		
Completed	15. Dacedant's I (Specify only highast g		16a. Decedant's 1	Usual Occupation  f work dona during most of	of working	16b. Kind of Bu	usinass/Indu	istry		
Ě	Elamantary/Secondary (0-12)	College (1-4or 5+)	Me DONO	T use retired)		1	i	6:00		
	97h	.at	LHOU	KtK	Alama (Propagation)	CONS	TYUC	7 1011		
To Be	17. Father's Name (First, Middla, Las HOULE BROBE	DEN SR.		MAK.	s Nama (First, Middle,	DNE.	3			
	19a Informant's Name/Ralationship Sharow Dut	TON- COUSIN	19b. Mailing Add	drass (Straat and Number	or Rural Route Numbe	C, Mb	Stata, Zip C	Coda)		
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Crametion 3 4 ☐ Donation 5 ☐ Othar (Spec	Ramoval from State	Place of Disposition cematery, crematory		0/10/0G	ANS/VI	City or Tow	m, State M/).		
	21. Signature of Poperal Service Lio		22. Nam	a and Addrass of Facility	GARY P.	MARC	HFU.	WEERL HA		
	June	harch	pcfU	I KEDHILTOI	V PASS BI	9010,1	710	21227		
	23a. Part Enter the disease, or cor shock or heart failura. List onf	mplicetions that causad tha dea y ona causa on each line.	ith. Do not antar tha	moda of dying, such es ca	ardiac or respiretory er	rast,	1	Approximata ntarval Batwaan Onsat end Death		
	Immediata Causa (Final disaesa or condition			1	l year					
	resulting In daath)	Ī								
Examiner		1 4	months							
хап	Sequentiafly list conditions, if eny, leading to immadiata causa. Entar Undarlying	Dua to (	or as a consequance	of):						
	Causa (Disaasa or injury AIDS Dementia									
Medical	that initiated avants rasulting in daeth) Last				months					
Physician/N	Part ff. Other significant conditions	ntribute to t	the cause of deat							
					101	res 20 No	3 Proba	ıbly 4□Unkno		
Completed by					24a. Was a perfor	an autopsy med?	com	a autopsy findings feble prior to pletion of causa seth?		
E					1 D Y	as 2 No	10	Yes 2□ No		
Bec	25. Wes casa rafarrad to medical	na)								
2	examinar? 1 ☐ Yas 2 <b>∑</b> No	Hospital: 1 Inpatiant 2	☐ER/Outpatient 3□	DOA Othar: 4 Nurs	ing Homa 5 🗆 Rasid	lance 6 Oth	ar (Specify)			
	27. Manner of Daath 1 ☑ Natural 5 ☐ Pending 2 ☐ Accidant invastigation	28e. Data of fnjury (Month, Day Year)	red							
Certification:	3 ☐ Suicide 6 ☐ Could not determined	28e. Plece of Injury - At homa, farm, straat, factory, office building, etc. (Specify)  28f. Location (Straat and Number or Rural Routa Number of City or Town, Stata)								
	29a. Certifiar (Check only one)  Cartifying Phyalcian: To the bast of my knowledge, death occurred et the time, date and piece, end due to the ceuse(s) end mannar as stated.  Check only one)  Cartifying Phyalcian: To the bast of my knowledge, death occurred et the time, date and piece, end due to the ceuse(s) end mannar stated.									
ᇹ	29b. Signetura end titla of cartifier	d (Month, D	ay, Year)							
Med	- Mari		29d. Data signed (Month, Day, Year)							
Medi	//6.						9/10/98			
Medical	30. Name end eddress of person who	completed cause of death //to	m 23e) (Type Brief)	D30494		09/10	)/98			



				Ce	rtificate of		Re	g. No.	4.0	3549			
	Physician	1. Decedent's Name (First, Middle, I		2			2. Date of Death Month	Day	Year	3. Time of Deeth			
8	/Medical	MICHAEL THOM  4e Facility Name (If not institution, g			4b. City, Town, or Lo	SEPT.	15,		6:25 P.M.				
	Examiner	3309 WOODSTOCK				BALTIMO			N/A				
	Funeral		Sex 7. Age	e (In yrs. last birthday,	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		-	ice (Stete or Foreign			
	Director	346-01-9440 Usuel Residence of Decedent	1ÅM 2□ F	Yrs.	Months Days	Hours Min.	MAY 5,	1912	OHIO	<i>Y'</i>			
with the Maryland	at del	10a. State 10b. County		10c. City, Town or L					100	d. Inside City Limits			
N SK	or 28e-f.	MARYLAND	N/A			IMORE	1.00						
6	P 10	10e. Street and Number	UEVUE		10f. Zip Code 2 1 2	12	10g. Citizen of What Country?  U. S. A.						
6	items 23e or 28e-f short sher must be notified at Funeral Director	3309 WOODSTOCK A	12. Wes Decedent 8	ever in U.S. 13.			city Yes or No-		- American	n Indian.			
5-0020 72 hours after d	Examiner Examiner by Fun	1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces?	lo l	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	tispanic Origin? (Spe an, Mexican, Puerto I Specity:	Rican, etc.)		k, White, et				
5-0	aleal fical peted	15. Decedent's (Specify only highest of		16a. Dece	dent's Usual Occup	pation during most of working)	10	6b. Kind of Bu	siness/Indu	istry			
1121 within	ypiens, wr than "natur t, the Medical Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)				HUTNO	AND C	ELLTNC			
d b		12TH GRADE  17. Fether's Name (First, Middle, La:	st)	SELF	-EMPLOYEL	- SALESM		BUYING A		ELLING			
Maryland 21215-0020	ked off	PASQUALE SIMONE					RRIERE S		~,				
lan	ama ma	19a. Informant's Neme/Relationship	(Type, Print)	19b. Mail	ing Address (Street	and Number or Rura	l Routa Number,	City or Town,	Stete, Zip C	lode)			
61	n 27	MARY ANNA CARRIE	R (WIFE)			CK AVENUE,							
Baltimore,	0 = 0	20a. Method of Disposition 1 X Burial 2 ☐ Cremetion 3	☐Removal from State		metory or other pla			Oc. Location - 0					
ting b	riant.	4 Donation 5 Other (Spec	**		Y REDEEME		/18/98 B	ALIIMUH	KE, MA	AKYLANU			
Ba Ba	impo any i anse	21. Signature of Funerel Service Lic	volack,	1 5	2. Nama and Addre CHIMUNEK 331 BREHM	FUNERAL H IS LANE, B	OME INC. ALTIMORE	, MARY	LAND	21213			
		23a. Pert1. Enter the disease, or co shock, or heert feilure. List on	mplications that caused by one cause on each lin	the death. Do not en	ter the mode of dyir	ng, such es cardiac o	r respiretory erres	st,	1	Approximata nterval Between Onset and Deeth			
//	ysician Aedical aminer	Immediate Cause (Final disease or condition resulting in death)  3 date											
	ě	Due to (or as e consequence of):											
sacuted	in end rai-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to (or as a conse	quence of):	The second							
928	TO B	Cause (Disease or injury that initiated events resulting in death) Last	C	VE DIST									
Box 1	Male N		d										
. 8	of for use	Pert II. Other significant conditions	contributing to death bu	rt not resulting in the u	inderlying cause giv	ven in Part I.	23b. Did 10b	acco use con	tribute 10 t	the cause of death?			
P.O.	igned by the ettending be deteched for use by Physician/M	Dementi	~				1 🗆 Ye	2 2 No	3 Probe	ably 4 Unknown			
Ords	should be						24a. Was an perform		avai	e eutopsy findings lable prior to pletion of cause aath?			
I Rec	page 2						1□ Yes	200 No	1 🗆				
	rector, par	25. Was casa refarred to medical				26. Place of Death		/		100 12 110			
of Vita	9 0	axaminer?	Hospital: 1 ☐ Inpaties	nt 2 ER/Outpatie	nt 3 DOA Oth	vor	ne 5) Resider		er (Specify)				
Vision o	tor: After th the funeral cation:	27. Manner of Death  1 Netural 5 Pending 2 Accident investigati	28a. Data of Injur (Month, Day	Year) 28b. Tima o	Woo	yat rk? Yes 2 □ No	28d. Describe hov	v injury occurr	ed				
S 8 5	al Director: After to led in by the funera	3 Suicide 4 Homicide  6 Could not be detarmined  28e. Placa of Injury - At home, ferm, street, fectory, office building, efc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, Stete)											
Hospital     A house	within 24 hours after death.  Ye the Funeral Director: After the completely filled in by the funeral Medical Certification:		thysician: To the best of aminer: On the basis of and manner same										
To the	Toth	29b. Signature and title of certifier	114	I HEAD	29c. Licens	e number	29	29d. Dete signed (Month, Dey, Year)					
19			7 Dece	0	D	20673							
	2	30. Name and address of person who	completed cause of de			XUV.		1	-1-15	-			
		31. Date filed (Month, Day, Year)	or mo	7672 P	selair Gr	40 212	36						
	State Registrar			ers Signature	Span	S							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #5,20b Per FH Film G763 9-17-98rc Certificate of Death 3. Time of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** ARTHUR COHEN 1:40 pm 1998 September 12 /Medical 4a Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Sinai Hospital of Baltimore Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day Year) NOV 24, 1920 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex Birthpleca (Stete or Foreign Country) **Funeral** 1 M 2□ F 214-20-1920 77 Yrs. MD Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 Yes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 6 2205 CREST ROAD 21209 238 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 222No If Yes, Give Year or Dates: 14. Raca - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Bleck, White, etc. 1 Never Married 2 Married natural', or 1 Yes 2X No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiena. Is marked other than Elementery/Secondary (0-12) College (1-4or 5+) OWNER REAL ESTATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and 2 should be COHEN MORRIS COHEN YETTA 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Health a SARAH COHEN / WIFE 2205 CREST ROAD BALTIMORE, MD 20b. Place of Disposition (Name of cametery, cremetory or other piece) 20c. Location - City or Town, Stete 20a. Method of Disposition Pages 75 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MIKRO KODESH BETH ISRAEL 9/14/98 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Preumonia **Examiner** Due to (or es a consequence of): Physician/Medical Examiner - Hodgkins cate be axecuted physician and s the burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last 68760 Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evelleble prior to completion of cause of death? 24e. Wes an eutopsy performed? Completed No certificate Physician: 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) 1 ☐ Yes → No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending Investigation or Attending Naturel 1 Tyes 2 No il Director: Af 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours a Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date end pleca, end due to the ceuse(s) and menner es steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) end menner stated. edical 29a. Certifier (Check only one) within 2

nown

State Registrar

Kathryn 31. Date filed (Month, Day, Year) SEP 1 5 1998

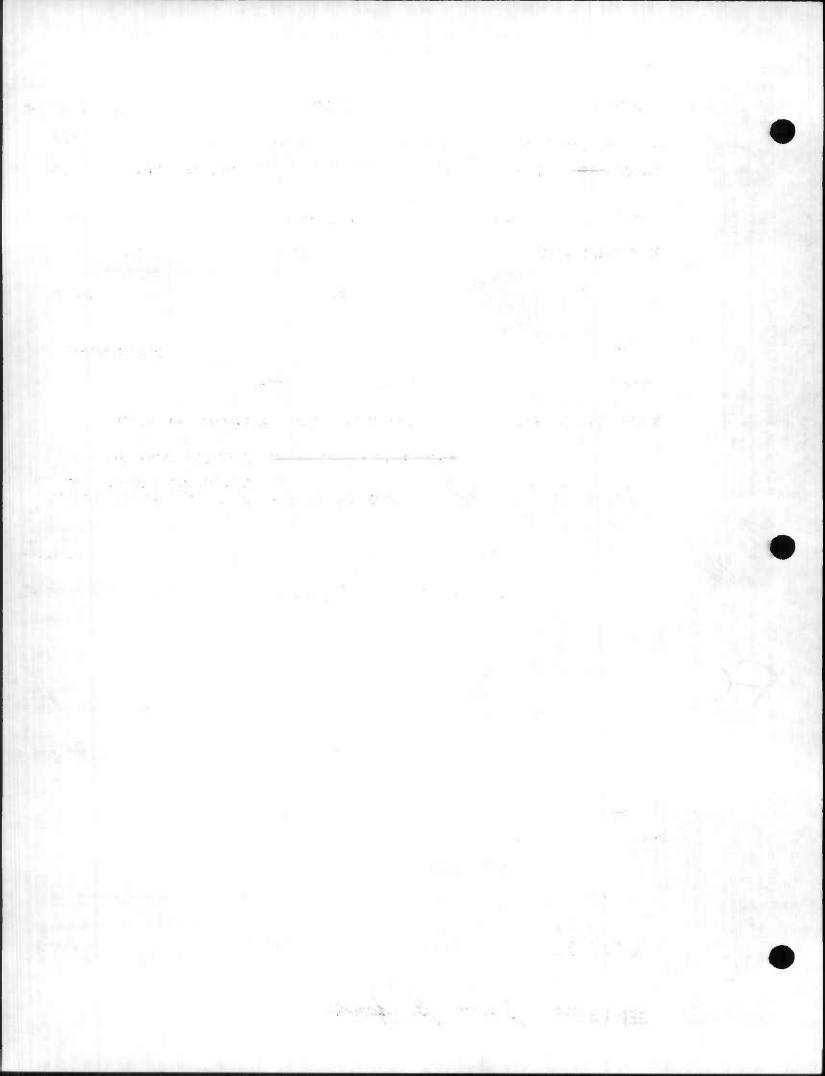
29b. Signature and title of

Barnard 82. Registrar's Signatur

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Dey, Year)



of Maniford / Department of Health and Mantal Hydiana

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TON	VY A. CO					Certific		Death		Reg. No.	6. (			
,	Physician	1. Decedant's Name (First, Middle, Last)							2. Data of D Month	Day	Year	3. Time of Deeth		
	/Medical	TONI A. COA, JR.							SEPT.	13, 199				
	Examiner	F10-15-15-15-15-1		va straat and number)				4b. City, Town, or		th 4c. County	of Death			
				OGA STREE			adas 4 Vans	BALTIM		N/A				
	Funeral Director	5. Social Security  WWK  Usual Rasidance		DAM OFF	ge (In yrs. last L 27	Yrs.	nder 1 Year ths Days		(Month, D	o, 1970	9. Birthi Cou	placa (State or Foreign http) YLAND		
	pue *	10a. State	10b. County		10c. City, To	wn or Location						IOd. Inside City Limits		
	or 28s-1 show or control of the cont	MD . 10e. Street and N	N,	/ A	BAL	TIMOR	E. Zip Coda			10g. Citizen of V	What Cou	1 XYas 2 □ No		
	With With	Too. Street and IV	ioni per									,		
	eral	823	W. SARA	TOGA STR	EET	13 Was D	212	201 Hispanic Origin? (S	Specify Yas or N	U.S. 0		can Indian,		
Maryland 21215-0020	72 hours after deeth with the Meryland natural; or items 23e or 28e-4 show lifest Evantine transit to notified a steel by Funeral Director	1 X Navar Ma 3 ☐ Widowed	irriad 2 Married 4 Divorced	Armed Forces  1 Yes 2 If Yas, Giva  Year or Datas:	No	If Yes,	specify Cut	oan, Maxican, Puar	to Rican, atc.)		ck, Whita,			
0	natural',	10	15. Dacedant's E	ducation	16	a. Decedant's	Usual Occu	pation during most of wo	adelia a	16b. Kind of Bu				
218	c • 8 -	Elementary/Sec	ecify only highast grace condary (0-12)	College (1-4or		lifa. DO NO	T work done OT usa ratire	ed)	rking					
21	giene. pr than tre m	12TH		N/A		UNEMP	LOYEI	)		N/A				
pu	Se se la		e (First, Middle, Last	)				18. Mothar's Na	ma (First, Middle	a, Maiden Surnam	na)			
yla	should b nd Mente merked umetic e	TONY	L. COX					MAGEALE	ENE GEA	THERS	COX_			
ar	2000	19a. Informant's	Neme/Relationship (		15	b. Mailing Add	lress (Stree	t and Number or R						
	Health tem 27 other tr	TONY L. COX (FATHER) 4023 SPRUCE DRIVE BALTIMORE, MD. 2												
Baltimore,	of of		20a. Mathod of Disposition  1  Burial 2 Cramation 3 Removal from Stata  20b. Place of Disposition (Nama of cematary, cramatory or other place) 9 / 21 / 98  20c. Location - City or Town, Stata GEORGETOWN											
E	permit. Peges Department of I important: If its any injury or o once.		5 ☐ Othar (Special			OLIVE	BAPT	. CHURC	H CEM.					
	Physician /Medical Examiner	Immadiate Ceuse disaase or condit rasulting in daath	r the diseasa, or com aart feilura. List only e (Final tion	pplications that curve on a cause on (1) in a	Stra-	LEW 451 o not antar that	PAF mode of dy	GWYNN RK HEIGH ing, such as cardia	FUNER A	AL HOME		15-6393 MD. Approximate Interval Between Onsat and Death		
	executed when the contract of	Cognantially list	onnditions C	b	Dua to (or as	a consequence	of):				1			
ó	be executed clarkand buriel-transit	Sequantially list of fany, laading to cause. Enter Uno Cause (Disaasa	immadiata darlying		000 10 (01 00	a consequence								
×	ng physicate es the	thet initiated evar rasulting in death	nts	d	Dua to (or as a	a consequanca	of):							
	the etten the etten thed for u	Part II. Other sign	nificant conditions	contributing to death t	out not resulting	in the underly	ing causa g	ivan In Part I.	23b. Die	i tobacco use co	entribute 1	o the cause of death?		
۵.	that the ded by detection of Physics								10	1 Yes 2 No 3 Probably 4 Unknown				
ec	aw requir		TR B						per	s an autopsy formed?	av C:	lara autopsy findings vailable prior to ompletion of cause death?		
a	cate he				11 Yes 2 No 12 Yes 2 No									
Vital	ysician: The is certificate director, par	25. Wes case ref		Hospital: Other: A Chartest and										
-	Z SO	1 ∑ Yas 2 [ 27. Mannar of De		26a. Date of Inju		Outpatient 3E	JOOA	4 LI Nursing		how Injury occur		fy)		
Division	tal or Attending Ph is effer deeth.  al Director: After th ed in by the funeral  Certification:	1 Natural 2 Accidant	5 Panding Invastigatio	9/13/9	8 Year)	Tima of Injury M		Yas 200No	Subj	eit 87	Years	lad		
Ž	s effer de al Directe ed in by t	3 ☐ Suicida 4 Homlcida	6 Could not be determined	ZOW, Paggs of In	iury - At homa, is. (Specify)		ctory, office		28f. Location City or T	(Street and Numi own, Stata)	ber or Rui	al Routa Number,		
		3			AT 1	brut			18 236	N. XP	65 a	01		

ne Hospital or Atten n 24 hours efter deel ne Funeral Director: pletely filled in by the

29a. Certifier 29b. Sign

28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28/ Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) whome

1 Cartifying Phyaician: To the best of my knowladga, daath occurred at tha tima, data end pleca, and due to the cause(s) end menner as stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the tima, dete end place, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Day, Year) 29c. Licanse number

O.C.M.E

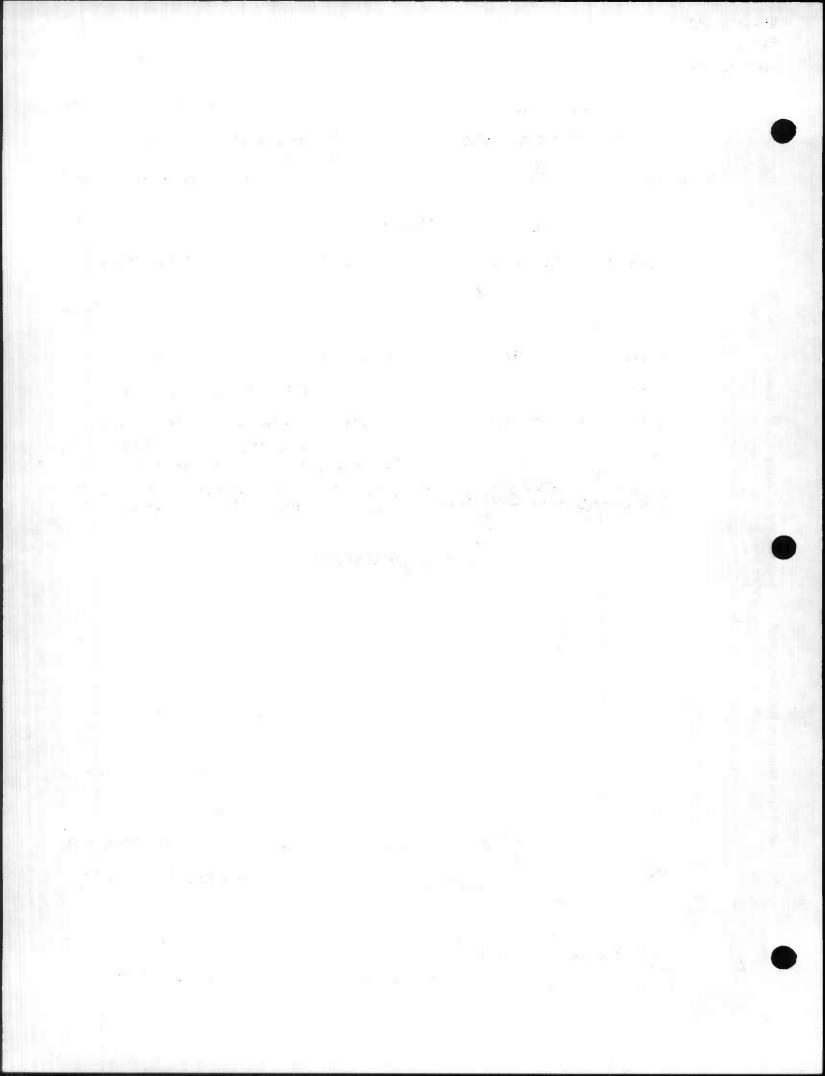
SEPT. 14, 1998

30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

The Street, Baltimore, Maryland 21201

State Registrar

Medicai



State of Maryland / Department of Health and Mental Hygiene

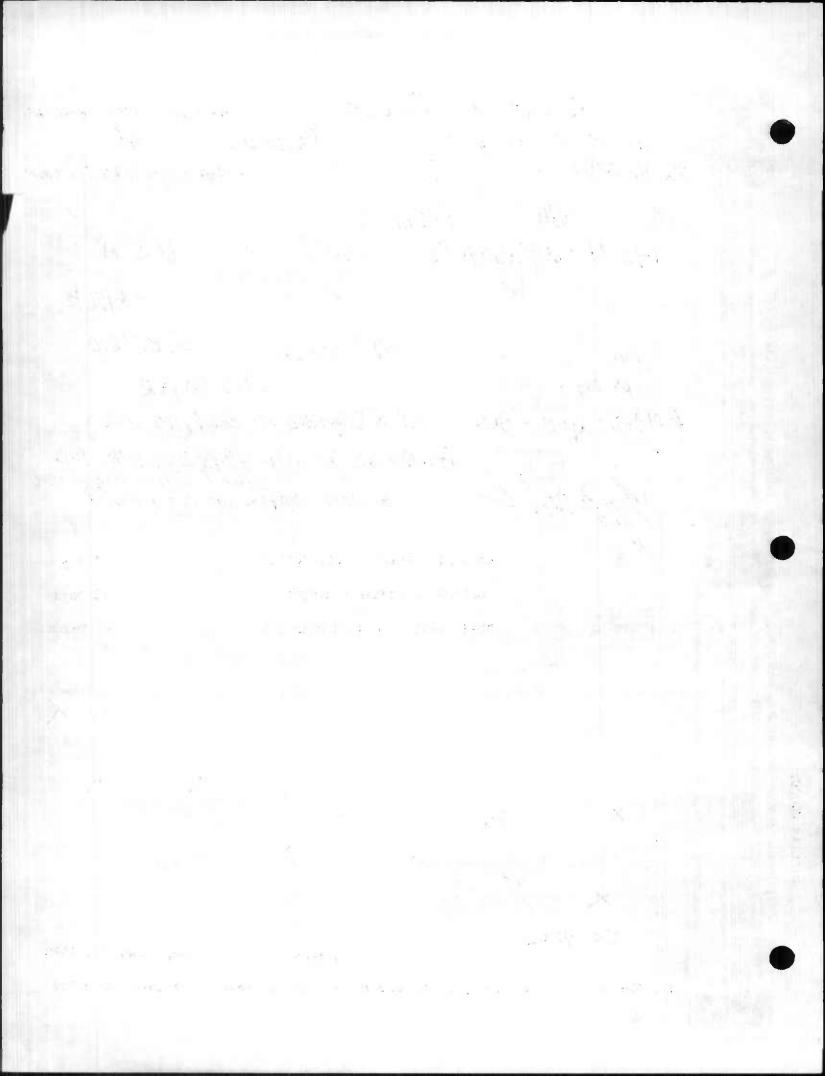
Item: 17 per F.H. G-763 9/17/98 reb Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) **Physician** September 9 1998
City, Town, or Location of Death 4c. County of Death 06:05 AM /Medical 4c. County of Death 4a Facility Nama (If not and number Examiner BALTIMORE If Undar 24 Hrs. 8. Da 7. Aga (In yrs. last birthday)
Yrs. If Undar 1 Year rity Number - 532 8. Data of Birth (Month, Day. 9. Birthplace (Steta or Foreign **Funeral** 100M 2DF Months Days Min 10 Director Usual Rasidance of Decedant with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Insida City Limifs 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner name be notified at 1 Yes 2 No Director 10g. Citizen of Whef Country? Funeral deeth 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11 Marital Status Armad Forcas? 1 ☑ Yas 2 ☐ No If Yes, Giva Year or Detas: Bleck, Whita, atc permit. Peges 1 and 2 should be filed within 72 hours after Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or its any Injury or other traumatic event, the Medical Examine. 1 Never Married 2 Married 1 Yas 2 No Baltimore, Maryland 21215-0020 Specify by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Giva kind of work dona during most of working
Mp. DO NOT usa retired)

ABLE SUCER 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast greda complated) ondery (0-12) College (1-4or 5+) 17. Fethar's Name (First, Middla, Last) 18. Mothar's Nama /First, Middla, Maidan Sumema) RICHARD **NELSON COOPER** (Streat and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Ralationship (Typa, Print) RICHARD 20b. Place of Disposition (Nama of 20a. Mathed of Disposition 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Ramovel from Stata Owings Mills, Veterans Cambery 9 Othar (Specify) 4 Donation MARCH PUNEFAL Home eral Sarvice License RSS 120 the disease, of complications that caused the art ailura. List only one ceuse on each line Approximata Intarval Batwaan Onsat and Death cations that causad the deeth. Do not enter the mode of dying, such as cardiac or respiratory arres **Physician** Immediate Ceusa (Final disease or condition resulting in death) /Medical CARDIAC ARRYTHMIA (CLINICALLY) 1 Day **Examiner** Dua to (or as e consequence of): Examiner CEREBRAL VASCULAR ACCIDENT 15 Days that the death certificate be executed and I-trans Sequantially list conditions, if eny, laading to immediata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in death) Last Dua to (or es a consaguence of): physician an s the burial-tr HYPERTENSION, ATHEROSCLEROSIS 40 Years Physician/Medical 98 esn 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions confributing to death but not resulting to the underlying cause given in Part I. the signed by t 1 Yes 2 No 3 Probably 4 Unknown þ Division of Vital Records, The law requires should ! 24b. Wera autopsy findings evaitable prior to Completed 24a. Was an autopsy performed? completion of causa of death? has 2 No certificate 25. Was case refarred to medicet axaminar? Be 26. Placa of Death (Check only ona, Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Certification: To 1 Yas 2 No Inpatiant 2 ER/Outpatient 3 □ DOA this 28d. Dascribe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 5 Panding Invastigation Netural 2 Accidant Attending 1 Yas 2 No death. ector: 6 Could not be 28e. Piece of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 3 4 Homicide Dire 6 within 24 Hours To the Funeral Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

The medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner stated. Medical 29a. Cartifiar (Check only one) 29b. Signature end titla of cartifier 29c. Licanse number 29d. Date signed (Month, Day, Yaar) September 10, 1998 D52540 30. Nama and addrass of person who complated ceusa of daeth (Itam 23a) (Type, Print) 6 Enelow St. Agnes HealthCare 900 Caton Avenue Baltimore, MD 21229 Thomas J. Registrar's Signature State Registra

DHMH 16 Rev 6/95

WILLIAM COOPER



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Dorothy R. Dunn September, 09, 1998 11:15 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Union Memorial Hospital Baltimore Baltimore City | H Under 1 Year | H Under 24 Hrs. | 8. Dete of Birth (Months Deys Hours Min. | Feb. 7, 1930 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months 217-26-26 9010 1 □ M 2 □ F 68 Yrs. unknown Director Usual Residence of Decedent 10d. inside City Limits unknown 1 | Yes 2 | No 10a State 10b. County 10c. City, Town or Location unknown unknown unknown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? unknown unknown U.S.A. Funeral 12. Wes Decedent Ever in U.S. Armed Forces?unknown 1 □ Yes 2 □ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Maritel Status Bieck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: Black by 3 ☐ Widowed 4 ₺ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 18. Mother's Name (First, Middle, Malden Surneme) 17. Father's Neme (First, Middle, Last) unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Betty Wilson/niece 20b. Plece of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any Injury or once. 4 □ Donation 5 □ Other (Specify) in state 21. Signefure of Funeral Service Licensee Wade, Director 22, Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 ut). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Respiratory days Failure disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner cell carcinoma Advanced squamous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Advanced SCIP years Physician/Medicai Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24e. Was en eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and tille of certifier 29c. License number 29d. Date signed (Month, Dey, Year) AT 2438 946 September, 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 201 E. University PKWY Memorial Dr. Wei Union Hospital LU 31. Dete filed (Month, Dey, Year) 32 Registrer's Signature State 171998 ooks SEP Buen

Registrar

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Baltimore, Maryland 21215-0020

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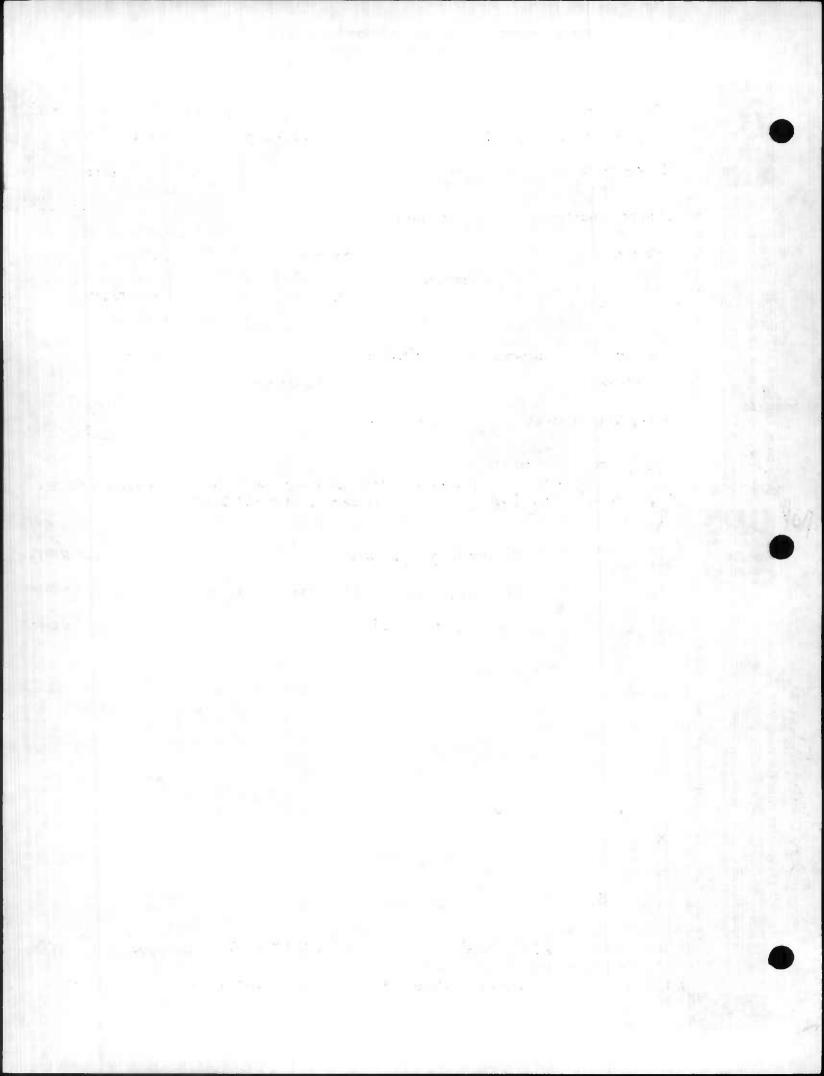
Direc

To the Hospital within 24 hours or To the Funeral Completely filled

The law requires that the deeth certificate be executed

or Attending Physician:

COSO TUTOLOGO



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#15,16a,16b per FH G763 9/30/98 EW 1. Decedent's Nema (First, Middla, Last) 2. Data of Daath 3. Tima of Death September 11, 1998 **Physician** Flossie Dedmond /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Nama (If not Institution, giva street and number) Examiner BALTMORE BAUT MORE CITY 2024 Whittier Avenue If Undar 24 Hrs. If Undar 1 Yaar 7. Aga (In yrs. last birthday) Yrs. 5. Social Sacurity Number **Funeral** Months Days Hours 1 M 2 D 220-36-153 Usual Rasidance of Decedant Director the Marylend 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumstic event, the Medical Examinat must be notified at Baltimore 1 Nas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? with 2024 USA 2147 Funeral Peges 1 end 2 should be filed within 72 hours efter deeth nent of Heelth end Mental Hygiene. Int: If Item 27 is marked other than "natural", or Itema 23. 12. Was Decedant Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Yas 2 No If Yes, Giva Yaar or Datas: 1 ☐ Nevar Married 2 ☐ Marriad 10 Specify: Black altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Businass/Industry
Coppin, State College 16a. Decedent's Usual Occupation
(Giva kind of work dona during most of working
lifa. DO NOT usa retired)

Drofossor 15. Decedant's Education (Specify only highast grada complated) Elementary/Secondery (0-12) Professor Collega (1-4or 5+) 12th or grade 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Father's Nama (First, Middla, Last) Be Johnetta John Wesley 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) /0553\_ Senera Avenue HtVemon NewYork Alice NewKirlL Important: if item 27 any injury or other transfer 20a. Mathod of Disposition

1 Burial 2 Cremation 3 Ramoval from Stata
4 Donation 5 Other (Specify) 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata permit. Pege Department o rematory 21. Signatura of Funaral Sarvica Licansaa 22. Nama and Addrass of Facility March F/H West lad Warre 4300 Wabash Avenue Baltimore, Md 21215 23a. Part1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each lina. Approximata Interval Between Onsat and Deeth **Physician** CANCER OF PANCREAS /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Examiner Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Boxr68760 Physician/Medical Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown P 24b. Ware autopsy tindings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed certificate has b lirector, page 2 s 1 ☐ Yas 2 No 1 Yes 2 No or Attending Physician: director, Be 25. Was case referred to medical axaminar? 26. Placa of Daath (Chack only ona) Othar: 4 Nursing Homa 5 Assidanca 8 Othar (Specify) 1 Yas 2 No 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Data of Injury (Month, Day Year) 27, Manner of Death 28b. Tima of 28d. Dascriba how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accident 24 hours efter deet Funeral Director: 6 Could not be datamined 3 ☐ Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straet, factory, offica building, atc. (Spacify) 6 4 Homicide 29a. Cartifian 🕍 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, data and place, and dua to the causa(s) and mannar as stated. edical completely 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. (Check only one) within 2 To the

Registrar

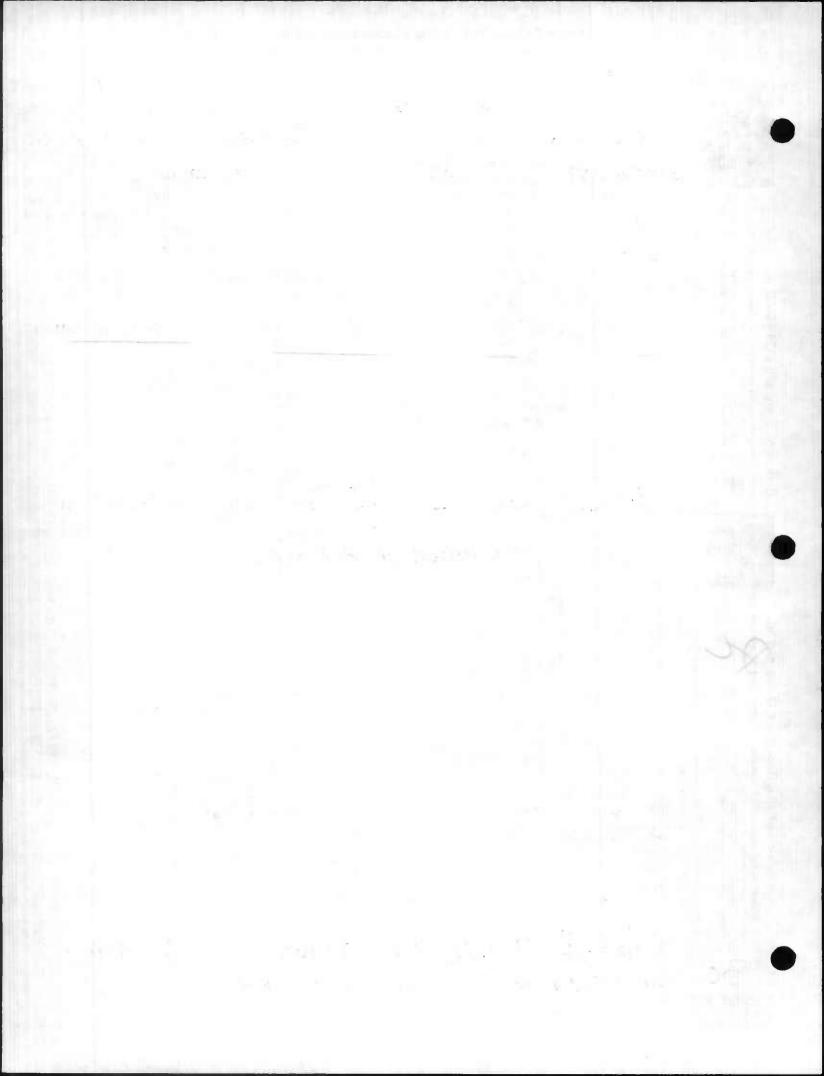
30. Nama and address of person who completed caus 3901 GREDSRING 31. Data filed (Month, Day, Year) SEP 171998

32. Registrar's Signatura

of death (Itam 23a) (Type, Print)

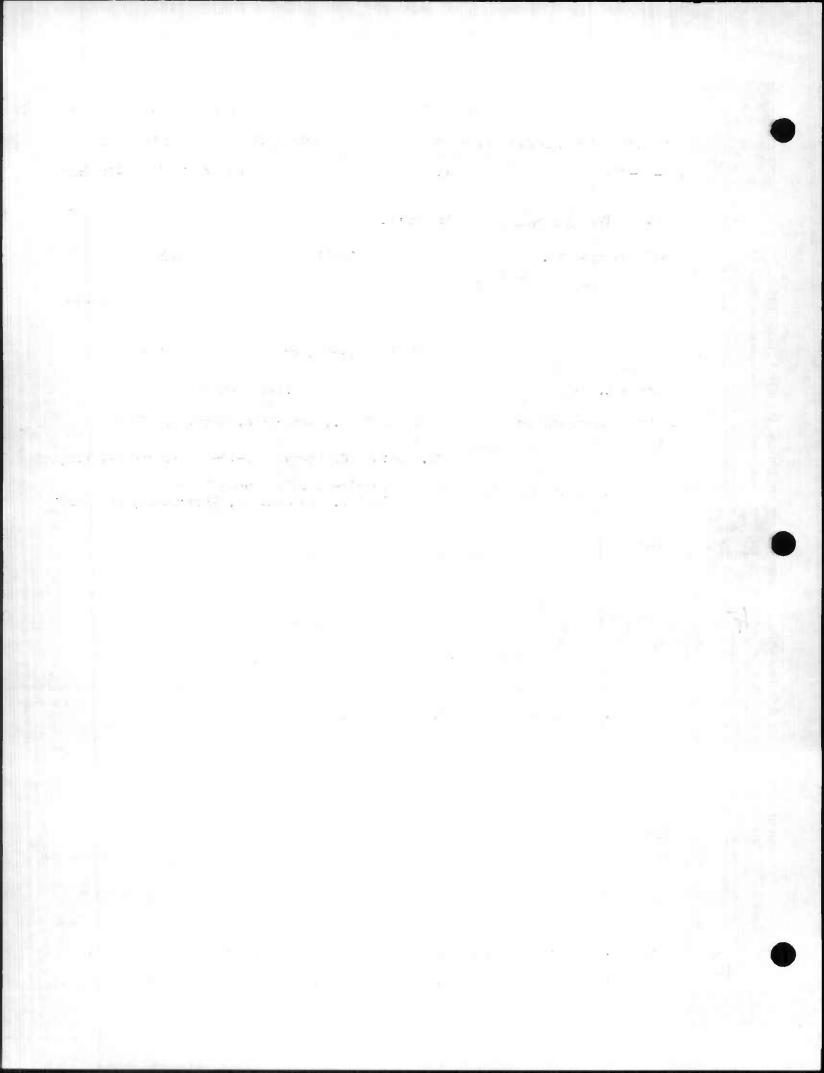
29c. Licansa number

29d. Data signed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene 9 8 - 28555

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/Medical Examine	An English Name /M not institution sine of				1 4	b. City, Tov	wn, or Loc	ation of Death	4c. County				
Examine	COLLINGSWOOD RETI	REMENT CENTER	2			ROCKV	TITE		MONT	GOMER	v		
- Francis	5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1	Year	If Under 2	24 Hrs.	8. Date of Birth			lace (Stete or Foreign try)		
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	1 2 Burial 2 Cremation 3 Re		cemetery, crei	metory or oth	her pled	e)							
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Baltimore, permit. Pages 1 a Department of Hee Important: If them eny Injury or othe page.	21. Signature of Funaral Service Licansac			2. Name and Everly	7-1/1h	00110	37 F11	Funeral Home					
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vician: The certificate rector, pag						26 Place	of Death	(Check only on	(a)	1			
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DIVISION of the plan of Attending P at a florector: After the funer led in by the funer.	4 Homicide determined	28e. Plece of Injury - At h building, etc. (Speci	fy)	raet, ractory,	Office		2	City or Town		on or Mura	raioute Number,		
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completaly filled in by the funeral		cian: To the best of my known: On the basis of examine end manner stated.	owledge, deat etion end/or in	h occurred a vestigation, I	t the tin	ne, date en pinion, dea	d place, a th occurre	nd due to the co	euse(s) end mate end plece,	end due to	eted. the ceuse(s)		
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10	30. Name and address of person who con	npleted cause of deeth (Iter	n 23a) (Type,	Print)									
	DAPhna Henkin	6082 an	Sho	refre	ld	200	ed C	wheat	m, no	5 50	20PC		
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Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Ren No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** DOLORES ANN ENDRES SEPT. 15, 1998 11:24 P.M. /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 18 DERWOOD COURT BALTIMORE BALTIMORE Hours Min. 8. Date of Birth (Month, Day, Year) A PRIL 25, 1933 If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Davs 1□ M 2X F MARY LAND 213-32-4179 65 Director Usuel Residence of Decedent 10a. Stata 10b. County 10d. Inside City Limits 10c. City. Town or Location 28a-f show Examiner must be nothled at 1 ☐ Yes 2 No Director MARYLAND BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ó Nems 23a 18 DERWOOD COURT 21234 U. S. A. Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 Ø No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, 11. Marital Stetus permit. Peges 1 and 2 should be filled within 72 hours effer c. Department of Health end Mental Hygiene. Important: if flem 27 is marked other than "natural", or flem sny injury or other traumatic event, the Hedgal Exercised once. Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE p 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 VEARS (1-4or 5+) Elementery/Secondary (0-12) OFFICE MANAGER EYE DOCTOR 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Be JOHN C. SPRINGER ANNA KUCHA 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES F. ENDRES (HUSBAND) 18 DERWOOD COURT, BALTIMORE, MARYLAND 21234 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel from Slala
4 ☐ Donetion 5 ☐ Other (Specify) GARDENS OF FAITH 9/19/98 BALTIMORE. MARYLAND 21. Signature of Funeral Service Licensee 22. Name end Address of Facility
SCHIMUNEK FUNERAL HOME INC Buan 3331 BREHMS LANE, BALTIMORE. MARYLAND 23a. Part1. Enter the disease, or complications that cause) the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear feiture. List only one cause on each one. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseasa or Injury thei initiated events resulting in deeth) Last Dua to (or as a consequence of): **Physician/Medical** Dua to (or as e consequence of) Box Per II. Open alignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Bid tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 | Yes 2 No 3 | Probably 4 | Unknown þ 24b. Were eutopsy tindings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No or Attending Physician: director. Be 25. Wes case referred to medical 26. Place of Beath (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No Certification:/To 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Neture 5 Pending n 24 hours after death.

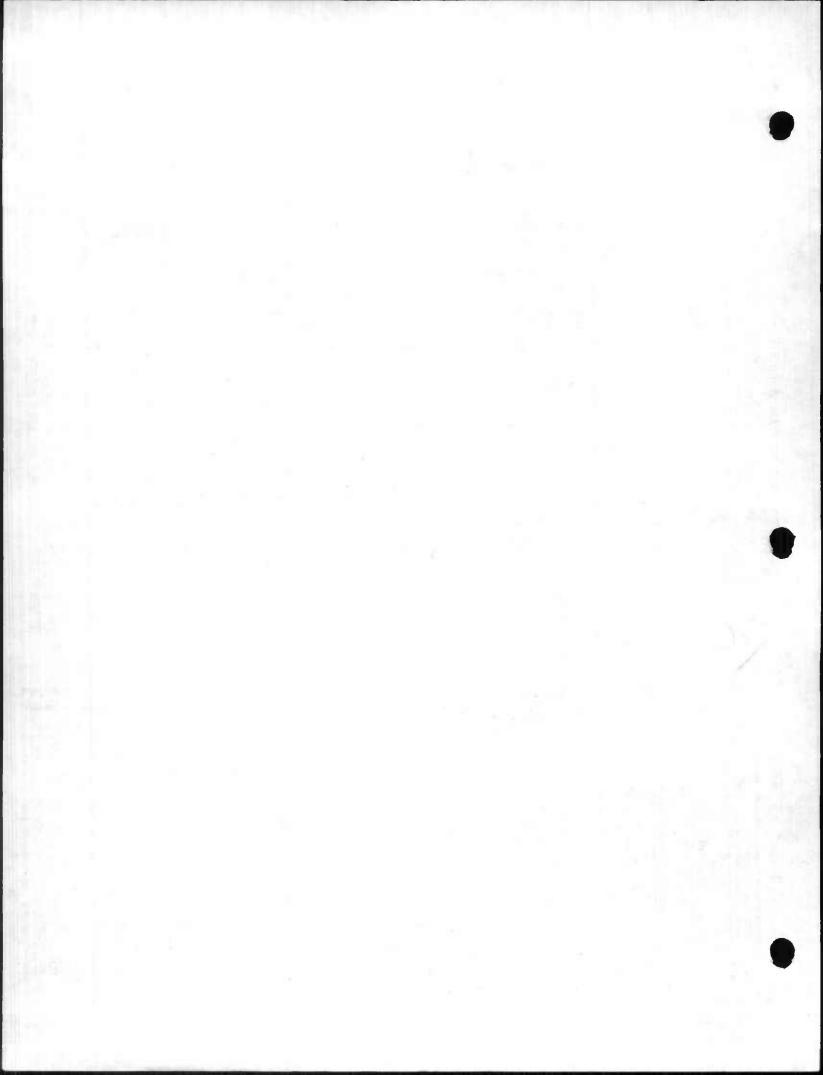
• Funerel Director: Aft pletely filled in by the fur 1 Yes 2 No Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suickla 28e. Plece of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Medical 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated. completely Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menger stated. (Check onh one) To the Vithin 2 29d. Date signed (Month, Day, Year)

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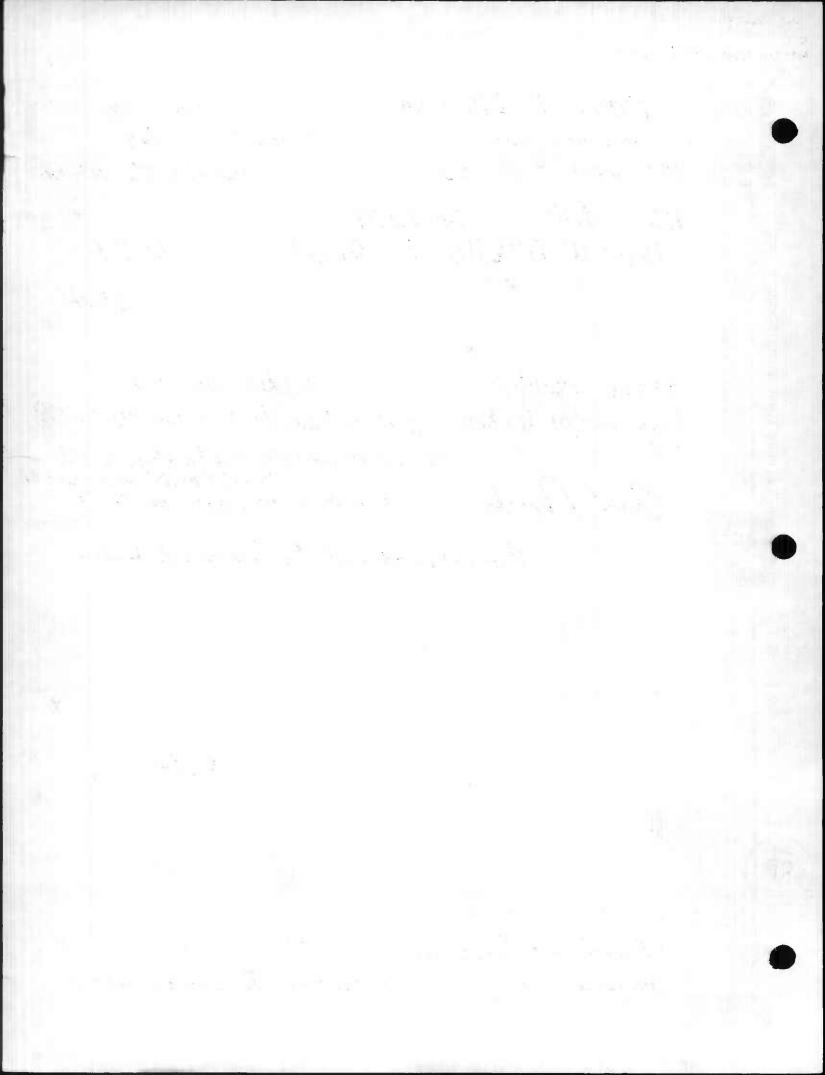
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	deeth with the Maryland rms 23s or 28s-f show r mass be not fred at	ctor	mb 10b. County N/A	10c. C	City, Town or Location				100	d. Inside City Limits 1 ✓ Yes 2 ☐ No
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5-0020	n 72 hours after deeth with the Maryler *natural*, or Nems 23s or 28s-f show *natural Examiner must be notified at		11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces?  1  Yes 2  No If Yes, Give Yeer or Detes:	U,S. 13. Wes Dece	edent of Hispenic Origin? (secify Cuban, Mexican, Pue 2 No Specify:	Specify Yes or No- to Rican, etc.)	Specify:	- America K, White, et B/A	
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	1 end 2 sho Health end em 27 is m ther traum		19a. Informent's Name/Reletionship (Ty	mother	19b. Mailing Address	Fayett	St. B	ALTO.//	70 6	21229
	permit. Pages 1 and Depertment of Health Important: If them 27 any Injury or other to page.		20e. Method of Disposition  1 Method of Disposition  1 Method of Disposition  1 Method of Disposition  3 Method of Disposition  3 Method of Disposition  1 Method of Disposition  2 Method of Disposition  3 Method of Disposition  1 Method of Disposition  2 Method of Disposition  3 Method of Disposition  4 Method of Disposition  5 Method of Disposition  1 Method of Disposition  1 Method of Disposition  1 Method of Disposition  2 Method of Disposition  2 Method of Disposition  3 Method of Disposition  4 Method of Disposition  5 Method of Disposition  1 Method of Disposition  2 Method of Disposition  1 Method of Dispos	arch 4	PELSIN FUEST 22. Name a 270 FK	Other place) APPEND CAMPLE CONTROL OF Address of Facility PEDHILTON AND	9/15/99 1 HARY P. 11 S. BALTO		PILLS, MARCHA 2122	MD. L Hone P. H. 29
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ploy		Certification:	27. Manner of Deeth  1 Naturel 5 Pending investigation 3 Suicide 6 Could not be	28e. Dete of injury (Month, Dey Year)	М	28c. Injury et Work? 1 ☐ Yes 2 ☐ No		ow injury occurre		
3	Hospital or At 24 hours Phero Funeral Direct stay tilled in by	Certifi	4 Homicide determined	building, etc. (Spec			City or Tow			
	To the Hostings or within 24 hours and To the Funeral Dis completely tilled in	edicai	(Check only 2 Madical Examir one)	elcian: To the best of my kner: On the basis of examined and menner steted.	nation and/or investigatio	n, in my opinion, death occ	urred et the time,	date end place, a	ind due to	the ceuse(s)
	To the within 2 To the comple	2	29b. Signature end title of certifier	1 Kind.	25	O.C.M.E.		29d. Date signed Septembe:		-5
5			30. Name and address of person who co	mpleted ceuse of death (Ite	em 23e) (Type, Print)	enn Street, 1	Baltimore	, Maryl	and 2	1201

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dey 13, 1998 **Physician** 9:22AM CARRIE MIRACLE **FOSTER** /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Newport Assisted Living Towson Baltimore 8. Date of Birth (Month, Dey, Year) June 23, 1913 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Months Deys Hours Min 10 M 20 F Yrs. 85 Tennessee 400-01-5835 Director Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Haalth and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experient must be notified anone. 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 3 No Directo Maryland Baltimore Towson 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 510 Valley View Road 21204 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes & M No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2XXNo Specify: White Specify: P X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Own Home 18 Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Unknown Unknown 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Son Lowell A Foster 2121 East Warm Springs Road #1012 Las Vegas NV 89119 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete XXBurial 2 Cremetion 3 Removel from State Crownsville Vetrans Cem 9/18/98 Crownsville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility 21 Service Licensee Mitchell Wiedefeld Home Inc 23a. Pert1. Enter the disease, or complications thet ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. 6500 York Road Baltimore, Maryland 21212 Approximete Intervel Between Onset end Deeth ayelous **Physician** Is/hole /Medical Immediate Ceuse (Fine) disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner ician end burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): Pert II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of death? Division of Vital Records, P.O. LINE signed by I 1 Yes 2 No 3 Probably 4 Onknown þ Lailora 24b. Were eutopsy findings evelleble prior to completion of ceuse of deeth? Completed 24e. Was en eutopsy certificate has t lirector, pege 2 s 1□ Yes 2 No 1 TYes 2 No or Attending Physician: 25. Wes cese referred to medical exeminer?

1 Yes 2 No funeral director Be 28. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA After this 28e. Dete of injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? 1 Matural 5 Pending 1 Yes 2 No death. investigation 2 Accident eftar deat Director: 6 Could not be determined a 24 hours efter des re Funeral Director plataly filled in by th

To the Hosp within 24 hor To the Fune complataly fi

Hospital

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 230) (Type, Print), EDDIE NAKHUDA 2300 DULANCY Valley Rd Timonium Mo 21093 NAKHUBA FDOIR 31. Dete filed (Month, Dey, Year)

1998

SEP

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one) 29b. Signature and

> 32. Redistrer's Signeture Brew

nos

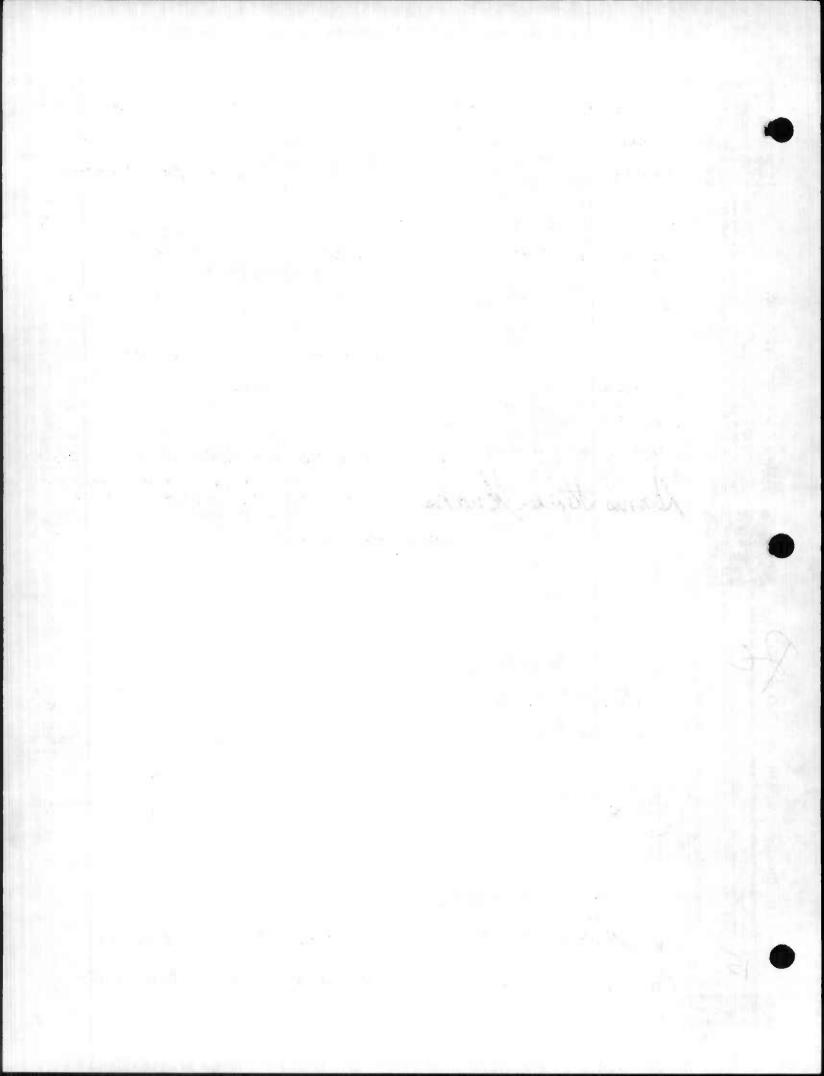
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Madical Exeminer: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) and menner stated.

29c. Liver)se number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dey, Year)



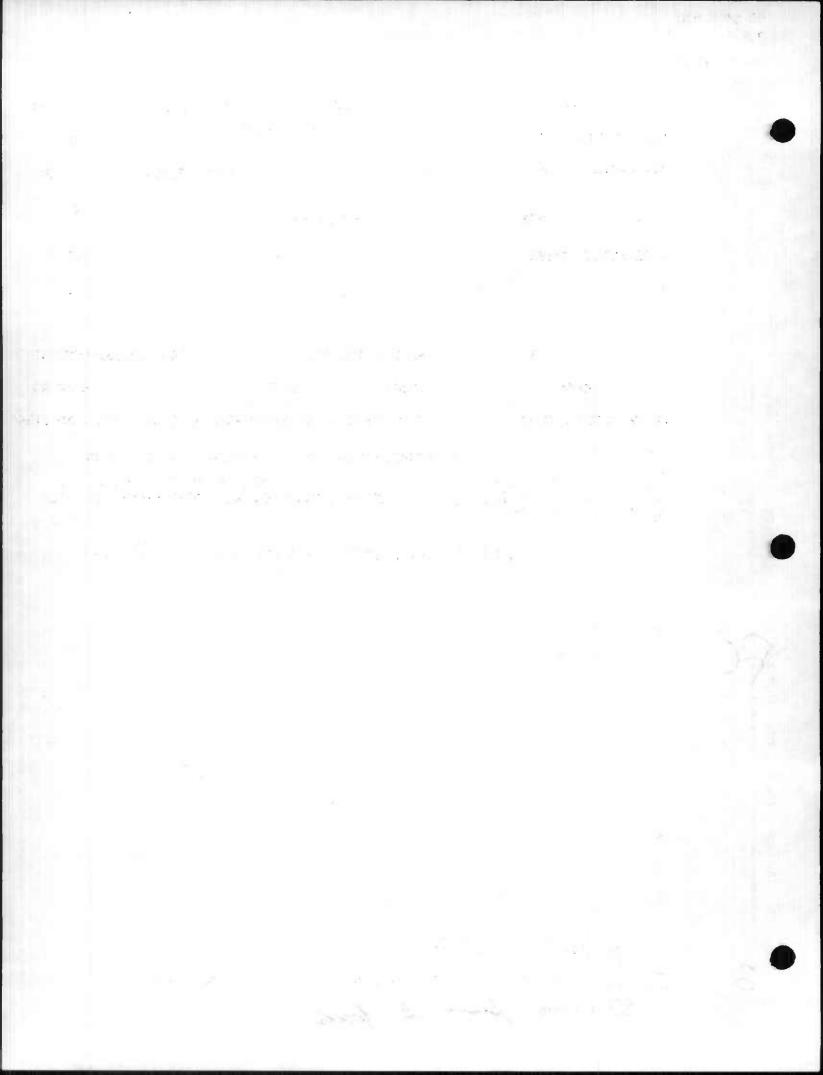
State of Maryland

/	Department of	Health and	Mental	Hygiene
	0-466-4-	4 Donath		

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				Certificate o	f Death		Reg. No.	-0000			
<b>D</b> I	1. Decedent's Name (First, Middle, Last	)				2. Dete of Dec		3. Time of Deeth			
Physician /Medical	HARRY			FREE	D	SEPT.	14, 1998				
Examiner	4a Fecility Name (If not Institution, give 4233 NADINE DRIV		M		4b. City, Town, BALTIM	or Location of Death ORE	RE .				
Funeral Director	212-30-3241	x 7. Age	(In yrs. last birth	Months   Day		8. Date of Birth (Month, Dey, Yeer) 9. Birthplace (S Country) MARCH 27,1950					
/lend	Usuel Residence of Decedent  10a. Stete 10b. County				10d. Inside City Limits						
ith the Man or 28s-f sh or notified Director	MD N	I/A		BALT		10a Citizan of MA	1 X Yes 2 □ No				
23a or	4233 NADINE DRIV	E		10f. Zip Code	21215			U.S.A.			
72 hours after death with the Manyland natural; or Hems 23a or 28a-f show deal Examiner must be notified at sted by Funeral Director	11. Marital Status  1   ↑ Never Married 2   ↑ Married  3   □ Widowed 4   □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N if Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cu		? (Specify Yes or No uerto Rican, etc.)	Specify:	- American Indien, , White, etc. WHITE			
Hygiena.  ther than "natural;  out, the Medical Exit.	15. Decedent's Edu (Specify only highest grad Elementery/Secondery (0-12)	cation e completed) College (1-4or 5-	+)	Decedent's Usual Occ Give kind of work dor life. DO NOT use reti	e during most of red)	working	16b. Kind of Bus	iness/Industry  OSS/BLUE_SHIE			
EISE A	17. Fether's Name (First, Middle, Last)		- ODK	TON OF BINA		Name (First, Middle,					
Men Men To	FRED	FRE		SELMA			SHAPIRO				
C	19a. Informant's Name/Relationship (T) GRACE FREED / AU			Mailing Address (Stre							
f Health fem 27 other tr	20a. Method of Disposition		20b. Place of E	Disposition (Name of cremetory or other p		Date #		City or Town, State			
mant of tant: If it land: If it land: If it land or o	1 ☐XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)			ON CHIZUK		9/16/98	BALTIMO	RE, MD			
permit. Pag Department Important: I any injury o	21. Signature of Funeral Service Licens	J		22. Name end Add		SOL LEVIN		OS., INC. E, MD 21208			
me an and brief-transit	Cause (Disease or injury that initiated events resulting In death) Lest  Due to (or as a consequence of):  d.										
an/Medical											
requires that the open signed by the man hould be detached for etect by Physician	Part II. Other significant conditions con	ntributing to death bu	t not resulting in t	the underlying cause		23b. Did tobacco use contribute to t					
has the page 2 s						24a. Was parfo	an autopsy med?	24b. Were autopsy finding available prior to completion of cause of deeth?			
certificate h rector, page	25. Was case referred to medical				26 Place of	Death (Check only )	Yes 2 No	1  Yes 2 No			
T di	examiner? XXX Yes 2 No  27. Manner of Deeth 1 X Natural 5 Pending	1 Inpatier 28e. Date of Injury (Month, Day)	y 28b. Tir	me of ury 28c. In	Other: 4 Nursing Nursi	ng Home 5XX esi	eath (Check only one)  Home 5 XX esidence 8 □Other (Specify)  28d. Describe how injury occurred				
deat ctor: y the	2 Accident Investigation 3 Sulcide 6 Could not be determined	28e. Place of Inju building, etc.	ry - At home, fam . (Specify)	M 1	28f. Location (City or To	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
within 24 hours after to the Funeral Directory filled in Directory filled in Medical Certification Medical Certification of the funeral Directory filled in Directory	29a. Certifier (Check only one) 1 ☐ Certifying Phy. 2 ☐ Medical Exami	alclan: To the best of nar: On the basis of end manner stat	examination and/	death occurred at the or investigation, in m	time, date and p	lace, and due to the occurred af the time,	cause(s) end men date and piaca, er	ner es steted. nd due to the cause(s)			
within To the compl	29b. Signature and title of certifier	m, N			nse number C.M.E		29d. Date signed SEPT 15	(Month, Day, Year)			
3	30. Neme and address of parson who co	ompleted cause of de	eth (Item 23a) (T	ype, Print) Penn Stree	t, Balti	imore, Mar	yland 21	201			

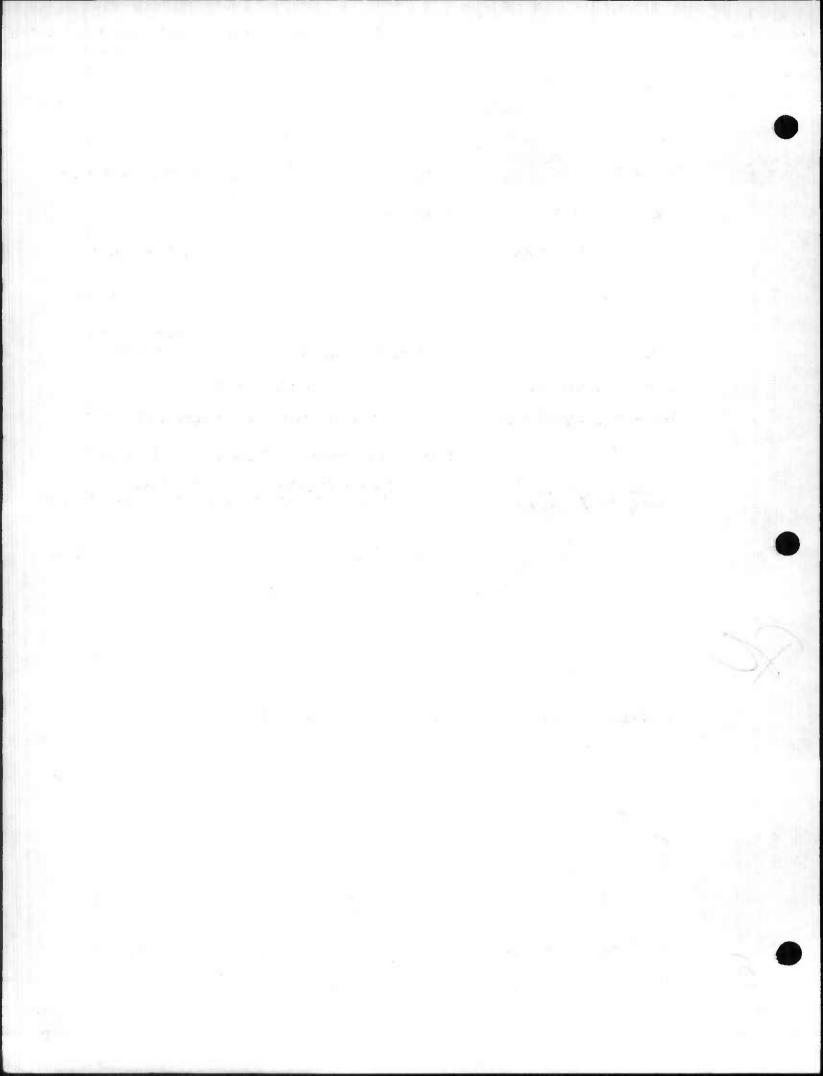
State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Daath 3. Time of Death Month **Physician** 1157PM SEPTOMBER 1998 /Medical 4b. City, Town, or Location of Deeth 4e. Facility Nama (If not institution, give street and number) 4c. County of Deeth **Examiner** BALT)
If Under 24 Hrs. BALTIMORE HOSPITAL MORE 6. Sex 1 → M 2 □ F 8. Data of Birth (Month, Day, Year) Dec. 26,1936 Birthplece (Stata or Foraign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 61 Yrs. 213-32-7090 Director Maryland Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumatic avant, the Medical Examiner must be notified at MD Baltimore N/A Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6 530 S. Newkirk Street 21224 United States permit. Pagas 1 and 2 should be filed within 72 hours after death will Department of Health and Mental Hygiane. Important: If fem 27 is marked other than "natural", or items 23a any injury or other traumatic avant. Its Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 1 ☐ Naver Merried 2 ☐ Married White Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: à 3 □ Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Local Union/ Eiamentary/Secondary (0-12) Collaga (1-4or 5+) Construction Insulation Installer 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Sumame) James E. Fales, Sr. Marion Bentz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Debra Cochran/Daughter 7837 St. Claire Lane, Baltimore, MD 21222 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place)
Green Mount Crematory 20c. Location - City or Town, Stata 1 Burial 2 Crametion 3 Ramoval from Stata 9-18-98 Baltimore, MD 4 ☐ Donation 5 ☐ Othar (Specify) <sup>22</sup> Name and Address of Facility CAFA - Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 Kunan 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwaan Onsat and Death **Physician** /Medical Immedieta Causa (Finel disease or condition rasulting in death) Examiner CARDIOVASCULAR disease Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disaasa or Injury that initiated avants resulting in daath) Last Physician/Medical Dua to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? Division of Vital Records, P.O. E 1 Yas 2□ No 3 Probably 4 Unknown Pulmonary disease (EMPHYSEMA) 24b. Ware autopsy findings aveilabla prior to complation of causa of death? Completed 24a. Was an autopsy performed? MALNUTRITION 1 Yas 2 PRIO 1 ☐ Yas 2 BHO 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: 1 Donpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) To 1 ☐ Yas 2 No 2 28c. tnjury at Work? 27. Mannar of Death 28a. Data of Injury (Month, Day Year) Certification: 28b. Tima of 28d. Dascribe how Injury occurred After 5 Panding investigation 1 Natural death 1 ☐ Yes 2 ☐ No 2 Accident Director 3 Suicida 6 Could not be 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) or A 4 Homicide To the Hospital o within 24 hours at To the Funeral DI 1 Cartifying Phyalclan: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifian 29b. Signatura and allo of certifian 29d. Date signed (Month, Day, Year) 29c. License number House officer 30. Name and addrass of person who completed causa of death (Itam 23a) (Typa, Print) SOUTH UNION 31. Data filad (Month, Day, Year) 32. Registrar's Signatura State Registrar



#### Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dev Yeer Month 30 Alice W Goodman AM September 13 1998 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) Baltimore City If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) AUG. 3, 1915 Sinai Hospital of Baltimore If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 1□M 2□F Months Deys 83 Yrs. 215-07-2516 MARYLAND Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND BALTIMORE BALTIMORE 1 ☐ Yes 2 ☐ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1 SLADE AVE, APT. 204 21208 USA 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ Mo If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 XNo Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 12 HOUSEWIFE OWN HOME 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) CHARLES WEILLER FLORENCE F. FRANK 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) MR. SOL W. GOODMAN (HUSBAND) 1 SLADE AVE, APT. 204 BALTIMORE, MD 21208 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 X Burlel 2 ☐ Cremetion 3 ☐ Removel from State BALTIMORE HEBREW 9-15-98 REISTERSTOWN, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Sinnature of Funeral Service Lig 22. Name and Address of Facility & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 on that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, as a on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final Pheumonia disease or condition resulting in deeth) Due to (or es e consequence of): Sepsis Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): thet initieted events resulting in deeth) Lest Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yas 2 No 3 Probably 4 Unknown COPD 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes an autopsy 1 Yes 2 No NIDDM 1 Yes 2 No 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 5 Pending Investigation 1 Yes 2 No 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Physician/Medical Examiner P Completed Be 2 Certification:

**Physician** 

/Medical

**Examiner** 

Director

Funeral

by

Completed

Be

**Funeral** 

**Director** 

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiens.
Int: If items 77 is marked other than "naturel; or items 23a or 28s-1 show that it of the 77 is the word; I'm hould be a not the standard to event, I'm hould be a not the standard.

Department of Important: If any injury or

**Physician** /Medical

Examine

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signed by the a

page 2

certificate funeral director,

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or Attending s after death.

Hospital 24 hours

altimore, Maryland 21215-0020

Division of Vital Records, P.O. Box

HTX

29e. Certifier

(Check only one)

25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Manner of Deeth

1 DNaturei 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

Location (Street and Number or Rural Route Number, City or Town, State)

112 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) and menner es steted. 2 Medical Examiner: On the basis of exeminetion end/or investigetion, In my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29c. License number 29d. Date signed (Month, Dey, Year)

599169

29b. Signeture end title of certifier

P12129

September 13, 1998

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Shelley A. Quarless Ph.D. DO, sinai Hospital, 2401 W Belvedere Ave, Baltimore, MD 21215 31. Dete filed (Month, Dey, Year)

State Registrar

SEP 1 5 1998

32. Registrer's Signature

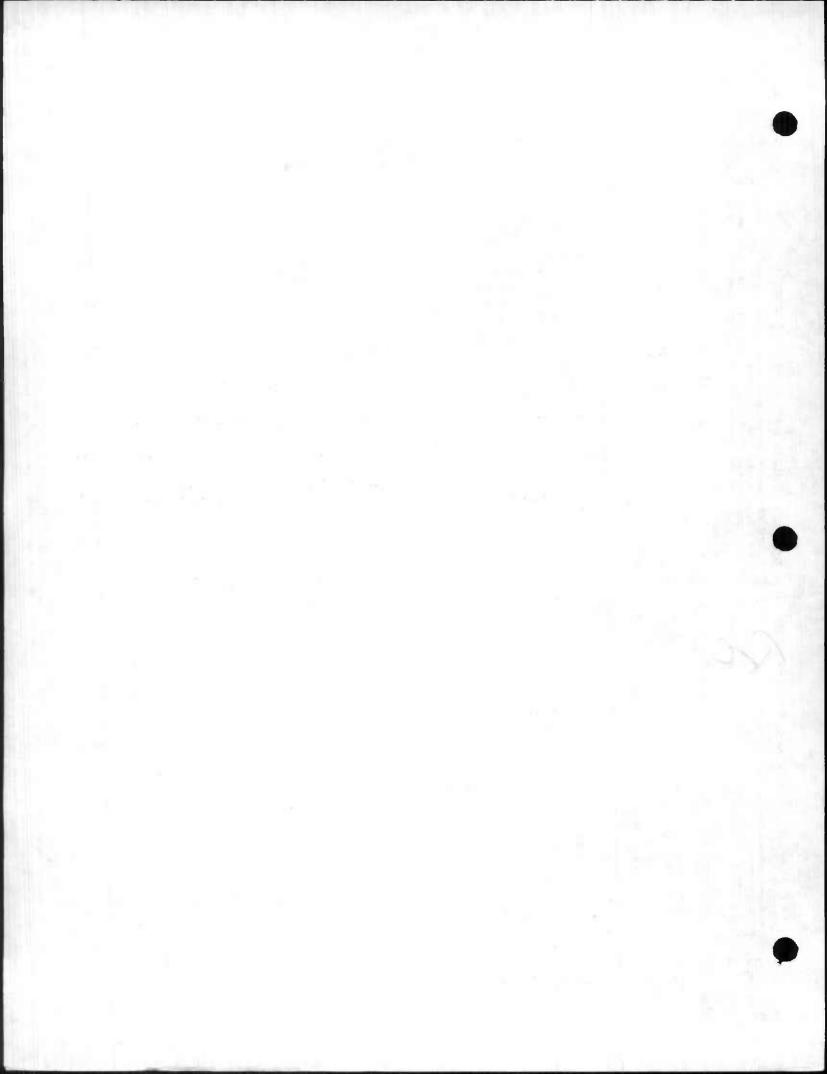
a d

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death SEPT. **Physician** MARGARET KOLETA 1998 11:00 A.M. HAUBNER /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner MARINER HEALTH OF OVERLEA BALTIMORE H Under 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year) SEPT . 28, 1913 If Under 1 Yaar 5. Sociel Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign
Country) **Funeral** Days Months GERMANY Yrs. 215-30-1203 84 Director Usuel Rasidance of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yas 2 No Director MARYLAND N/A BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Hygiene. other than "natural", or items 23s or death with 3525 DUDLEY AVENUE 21213 U. S. A. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 72 hours after 1 ☐ Yas 2 💢 No If Yas, Giva 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: You 3 X Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygiene Important: If Item 27 is marked other tha any Injury or other traumatic event, that once. HOMEMAKER 8TH GRADE OWN HOME 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be ADOLPH SCHMITT UNKNOWN MARIA 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) ANTHONY F. HAUBNER 3525 DUDLEY AVENUE, BALTIMORE, MARYLAND 21213 (SON) 20b. Place of Disposition (Nama of cematary, crematory or other place) 20e. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cramation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Othar (Specify) MOST HOLY REDEEMER 9/17/98 BALTIMORE, MARYLAND 21. Signatura of Funaral Sarvice Licensee 22. Name and Address of Facility
SCHIMUNEK FUNERAL HOME INC. Buin a. Wellen 3331 BREHMS LANE, BALTIMORE, MARYLAND 21213 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Finei disaasa or condition rasulting in death) SUDDET Examine Sequantially list conditions, if any, laading to immadiate causa. Entar Undarlying Causa (Disease or Injury that initieled avants rasulting in death) Last Box 58760 Due to (or as a consequenca of): Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. EMENTIA 1 Tyes 2 No 3 Probably 4 Unknown by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital Attending Physician: 25. Was casa referred to medical examinar? Be 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1□ Yes 2☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28b. Time of Injury 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. Director: Aft 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 T Homicide e Hospital or 7 24 hours after Funeral Dire 1 Corthying Physician: To the best of my knowledge, death occurred at the tima, data and place, end due to the cause(s) and mannar as stated.

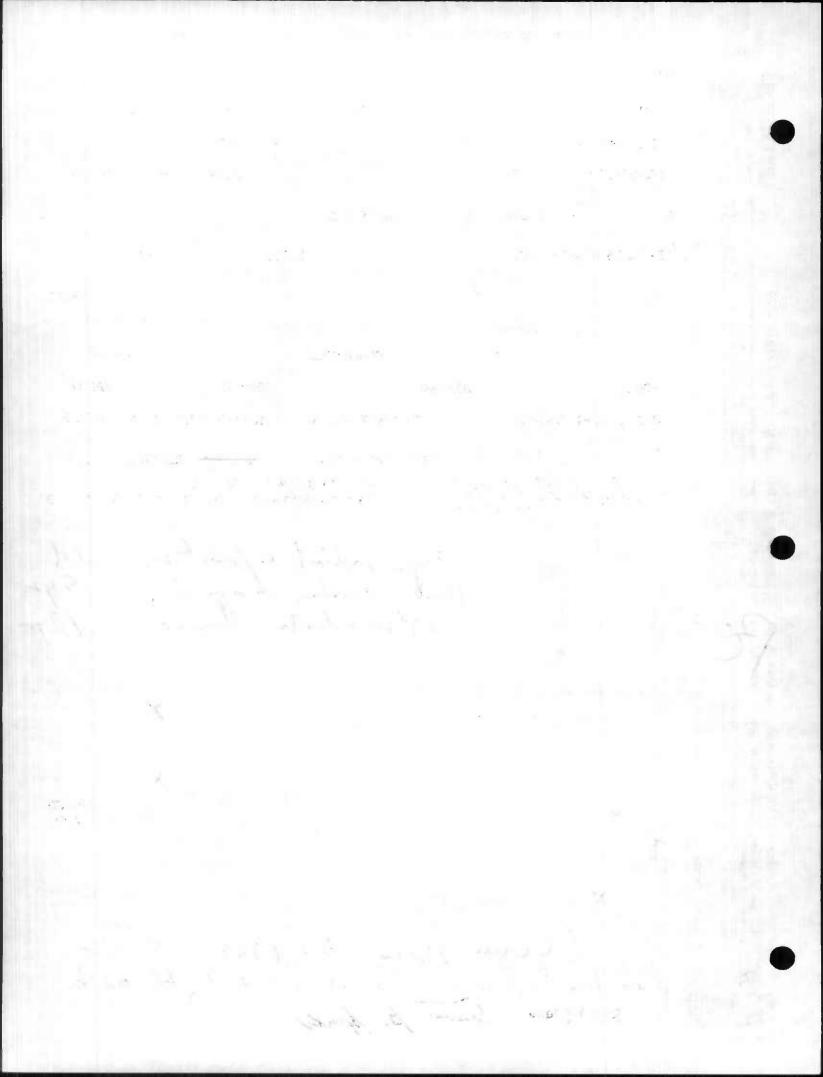
| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner steted. 29a. Certifier Medicai To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signetura end title of certifie 29d. Date signed (Month, Day, Year) 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) MO 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State 1

DHMH 16 Rev 6/95

Registrar



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8900 REISTERSTOWN RD. PIKESVILLE.  23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.  Immediate Ceuse (Final disease or condition resulting in death)  Due to (or es a consequence of):  Due to (or es a consequence of):  The property of the conditions, if env, leading to immediate ceuse. Enter Underlying									MD 21208 Approximate Interval Between Onset and Death					
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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEM: #23 PART II, PER MD G769 3-26-99 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** ROSA J. KOLKER SEPTEMBER 12 1998 4:15PM 4b. City, Town, or Location of Deeth 4c. County of Deeth /Medical 4a Facility Neme (If not institution, give street and number) **Examiner** GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F Months Days 214-16-3536A Yrs **Director** SEPT. 10, 1907 Usual Residence of Decedent the Marviend 10d. Inside City Limits 10e, Stete 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 23a-f shov traumstic event, the Medical Examinal must be notified at 1 ☐ Yes 2 ☑ No Director MD BALTIMORE LUTHERVILLE 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 515 BRIGHTWOOD ROAD 21093 U.S.A. Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-it Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 Yes 2√ No Specify: Specify: à 3 XWidowed 4 ☐ Divorced WHITE 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ! Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) SOCIAL WORKER JEWISH BENEVOLENT SOC 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Mentel Pages 1 and 2 should be ISAAC JACOBSON REBECCA KARP 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 80 I Health JONATHAN KOLKER / SON 3704 N. CHARLES ST. #701 BALTIMORE, MD altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition rtant: if he 1 M Burial 2 ☐ Cremation 3 ☐ Remo ARLINGTON CHIZUK AMUNO 9/14/98 BALTIMORE, MD 4 Donation 5 De tor (Speniy) 21. Signature of Fuseral Sex 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 lef the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** immediate Clause (Final disease or condition resulting in death) /Medical CARDIOPULMONARY ARREST Examiner Physician/Medical Examiner MYOCARDIAL INFARCTION Due to (or as e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury SEPSIS that initiated events resulting in deeth) Lest Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown à HIP À Sign 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy DEMENTIA-AND OSTEOPOROSIS 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 100 cartificate Division of Vital 25. Was case referred medical exeminer? Be 26. Plece of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Ng ui 4 T Homicide Hospital or 24 hours 29a. Certifier edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated. or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) Medical Examiner: On the basis of examination a To the To To the Comple 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and

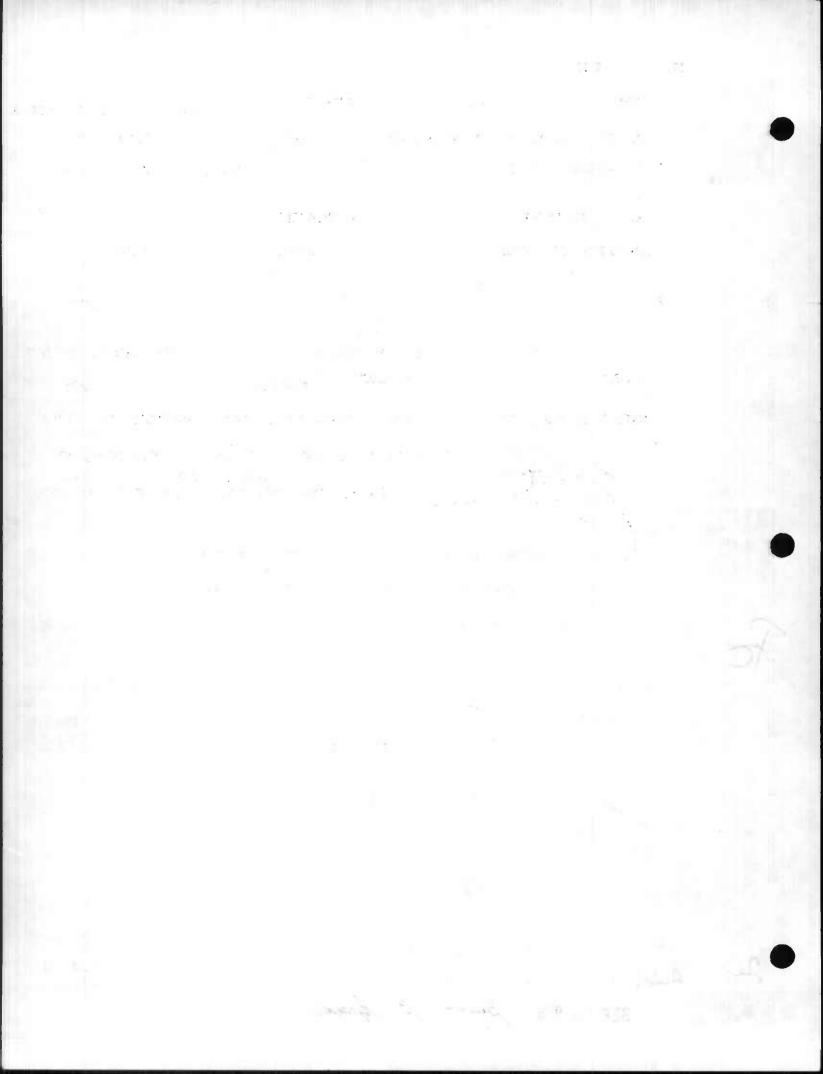
State Registrar 31. Date filed (Month, Day, Year)

SEP 1 5 1998

32. Registrar's Signature

3812 TIMBER VIEW WAS

(Type, Print)



State of Marvland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Deeth 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) Day **Physician** SEPTEMBER 13, 1998 8:45pm DOROTHY LEBO PACE /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Nama (If not Institution, giva street and number) Examiner 3114 MARNAT ROAD BALTIMORE BALTIMORE 5. Social Sacurity Number If Undar 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Dey, Yaer) JUNE 27,1910 9. Birthplaca (Steta or Foraign 7. Aga (In vrs. last birthday) **Funeral** 1□M 2XF Months Days Hours Min 262-09-5788 88 Yrs. MARYLAND Director Usual Rasidanca of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show 1 ☐ Yes 2 No MARYLAND BALTIMORE BALTIMORE Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? permit. Pages 1 and 2 should be filled within 72 hours efter death with the Department of Heelth and Mantal Hygiena. Important: If fram 27 is merked other than "natural", or items 23a or 2 with injury or other traumatic event, the Medical Express must be sone. 3114 MARNAT ROAD 21208 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 10 No If Yes, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, 11 Marital Status Black, White, atc 1 Nevar Merried 2 XMarried 1 ☐ Yes 2 No Specify: Specify WHITE à 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grada complated) Cottega (1-4or 5+) Elementery/Secondary (0-12) SECRETARY INTERNAL MEDICINE 18. Mother's Nama (First, Middla, Meldan Sumame) 17. Father's Name (First, Middle, Last) HAMLEN ANN WILLIAM MERRICK 19b. Meiting Address (Streat and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) 19e. Informant's Name/Ratationship (Type, Print) DR. LESTER LEBO (HUSBAND) 3114 MARNAT ROAD BALTIMORE, MD 21208 20b. Placa of Disposition (Name of camatary, crametory or other placa) Data 20c. Location · City or Town, Stata 20a. Mathod of Disposition 1 TBurial 2 Cramation 3 Ramoval from Stata DRUID RIDGE 9-15-1998 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Spacity) 22. Nama and Addrass of Facility 21. Signatura of Funeral Sarvica Licensaa SOL LEVINSON & BROS., TNC 23a. Part1. Entar the disease, or complications that caused in roboth. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 Approximete Interval Batwaan Onsat and Daath **Physician** /Medical Immediata Causa (Final disaese or condition rasulting in death) CARCINOMA OF THE LUNG YEAR Examiner Dua to (or as a consequence of) Examiner Sequantielly list conditions, if any, laading to immediata cause. Enter Underlying Ceuse (Diseesa or injury that initieled avents rasulting in death) Last and Dua to (or as a consequence of) Physician/Medical Due to (or as a consequanca of): 9 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown MYOCARDIAL INFARCTION by 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed completion of causa of death? 92 s certificata he 1 Yes 2 No 1 ☐ Yas 2 1 No 25. Was casa ratarred to medical exeminer? Be 26. Piece of Daath (Check only ona) Other: 4 Nursing Homa 5 Aesidenca 6 Other (Specify) 1 Yas 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 27. Manner of Daath 28c. Injury at Work? Certification: After 5 Pending invastigation 1 Naturat 1 Yas 2 No death. Director: A 2 Accidant 6 Could not ba 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 4 Homicide n 24 hours aft e Funeral Di oletaly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Cartifier edical pletaly (Check only one) within 2 To the 29d. Date signed (Month, Dey, Year) 29b. Signatura end titla of cartifiar 29c. Licanse number Serve M dom SEPTEM BEYL

Records, P.O. The law requires that the

Division of Vital or Attending Physician:

the Maryland

Registrar

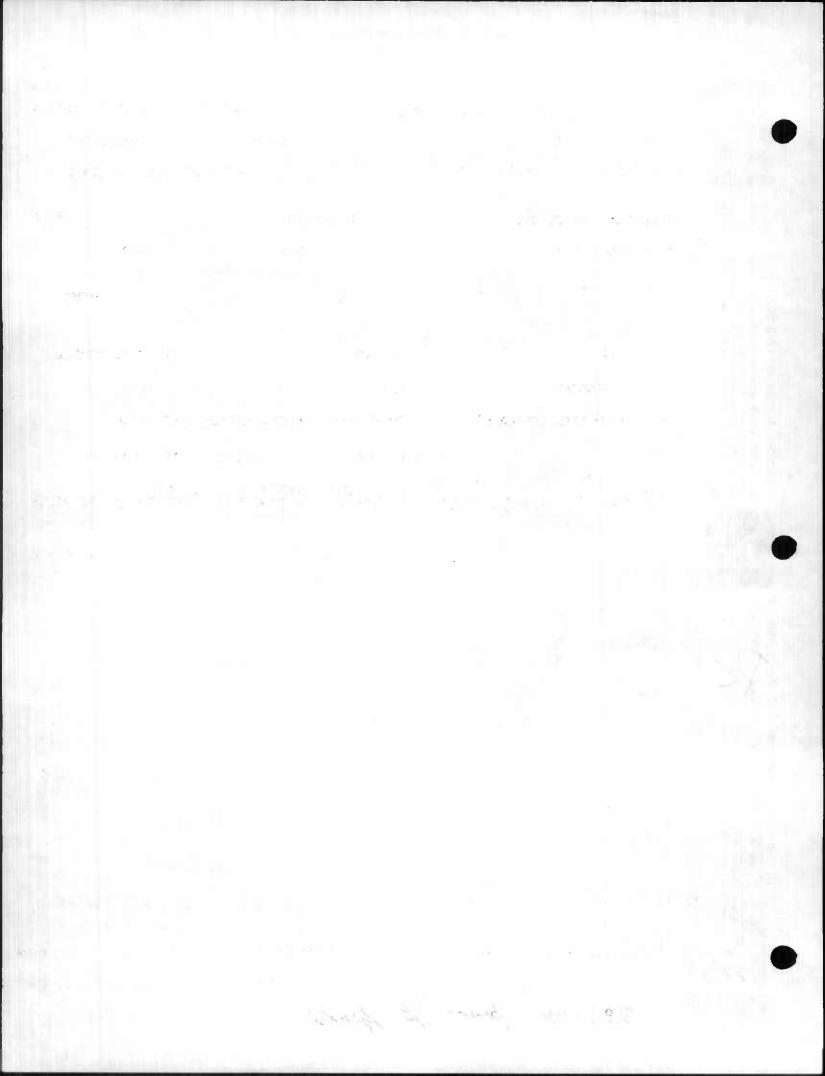
Comen M GENANS 31. Dete filed (Month, Day, Yaar) SEP 1 5 1998

30. Name and addrass of person who completed causa of daath (Itam 23a) (Type, Print)

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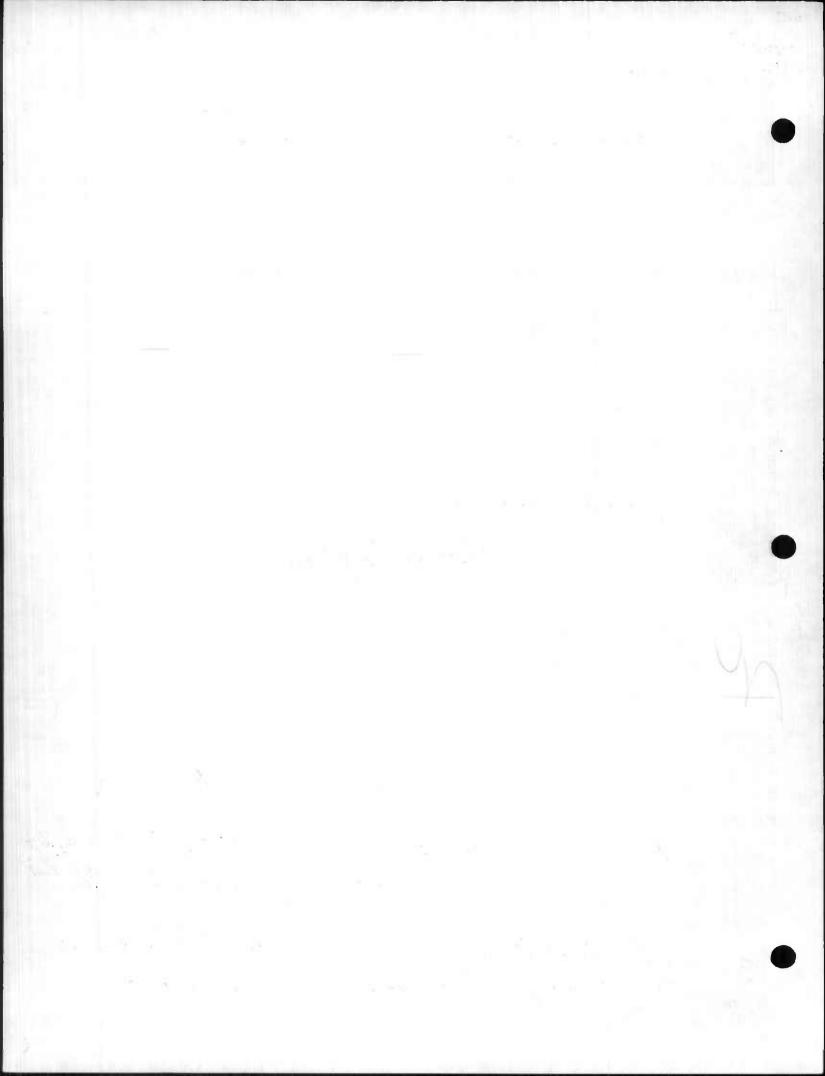
EAST FORT AVE

BALTIMULE, MD 21230



State of Maryland / Department of Health and Mental Hygiene

MMON Amend: #16a.b	Per FH Film G763 9-17-98	RPC	Certificate of	f Death	Re	g. No.	20000		
	1. Decedent'e Name (First, Middle, Last				2. Dete of Deetl Month	h Dey Ye	3. Time of Death		
Physician /Medical		Virginia (	_emon		SEPTEME		.998 5:24 PM		
Examiner	4e Fecility Neme (If not institution, give	street end number)		4b. City, Town, or Lo	cation of Deeth	4c. County of E	Peeth		
	JOHNS HOPKINS H	HOSPITAL		BALTI	MORE	N/A			
Funeral Director	223 OE 337 T	7. Age (In yrs. Ie.	st birthday) If Under 1 Yes  Months Dey		8. Date of Birth (Month, Pay, 10-11-	1935 9.	Birthpiece (State or Foreign Country) Md		
pug *	Usuel Residence of Decedent  10a. State 10b. County	10c. City.	Town or Location				10d. Inside City Limits		
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ifier deeth with the Me frems 23a or 28e4 e Aner must be notified Funeral Director	1308 N. Aisquith S		10f. Zip Code 21		USA				
ones a life.	11. Maritel Status  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. Wes Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:	1□ Yes 2ÅN		pecify Yes or No- Paican, etc.) 14. Rece Bleck Specify:		American Indien, Vhite, etc. Black		
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re, Maryland is a land 2 should be filed for the filed band Mental Hyg fem 27 is marked other traumatic event,	20a. Method of Disposition	20b. Ple	ce of Disposition (Neme of			12U / 20c. Location - City	or Town, Stete		
Page nent of mrt: If I	XX Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)	Arbu	tus Memorial	Park 9	-17-98	Arbutus,	md		
Baltim permit. Pa Deperment important: any injury pnce.	21. Signeture of Funeral Servica Licens	w ane	22 Name and Add March F, 4300 Wa	ress of Fedility 'H West abash Aveni	ue Balt.	imore. M	d 21215		
	23e. Pert1. Enter the disease, or compleshock, or heart failure. List only or	ications thet caused the deeth.	Do not enter the mode of d	ying, such es cardiac d	or respiretory erre	est,	Approximete tntervel Between		
/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	Due to (or	als gryu	uls					
68760, filcare be associated glovysican and as the burial-transit edical Examines	oddso. Enter original								
~ E / E = / Z		d							
al de le	Part II. Other significent conditions cor	stributing to death but not result	ing in the underlying cause :	given in Pert I.	23b. Did to	becco use contril	bute to the cause of death		
that the death-of- the that the attendance of detached for un- y Physician					1 🗆 Y	Probably 4 Unknow			
Division of Vital Records, to a Attending Physician. The law requires it after cleath. Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by entification: To Be Completed by					24e. Wes e		4b. Were eutopsy findings eveilable prior to completion of cause of death?		
Re ha to mo					12 Ye	es 2 No	1 Yes 2□ No		
Vital I sclan: Th certificate rector, pa	25. Wes case referred to medical			26. Piece of Deeti	n (Check only on	е)	1		
hysich hysich hysich diecer	exeminer? 1™ Yes 2□ No	fospital: 1 ☐ Inpatient 2005	R/Outpetient 3□ DOA	Wher:		enca 6 Other (	Specify)		
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Vis Anna Perde Perde Perde Perde Dy fi	Suicide 6 Could not be determined	28e. Pleca of Injury - At hom building, etc. (Specify)		0	28f. Location (St City or Town	reet and Number of	or Rural Route Number		
Div But or A rs after al Direction		January, ott. (openly)	raduray		Lovel Rel	timore &	anland		
cal ty fill	(Check only 2X) Medical Exami	sician: To the best of my knowl ner: On the basis of examinetic					er es steted. due to the cause(s)		
To the Hi within 24 To the Fo complete	29b. Signeture end title of certifier	and menner stated.	29c Line	nse number	2	9d. Dete signed (A	Aonth, Dev. Year)		
2328	1001	11.	200. 200	O.C.M.E.			12, 1998		
3	30. Name and address of person who co	empleted cause of deeth (Item 2	23e) (Type, Print)	0.0			. 10, 100		
-	THEODORE MIKIN		l Penn Street	, Baltimor	e, Mary	land 2120	1		
State Registrar	31. Dete filed (Month, Day, Year), SEP 1 7 1998	32. Registrar's Signetu							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #23b,24a,28a,b,c,e,29c Per MD Film G763 9-17-98RC Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** 14:34 MONEIL EUGENE DAVID 98 /Medical Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dete of Birth (Month, Day, 9. Birthpled Funeral Months Deys Min 728 - 09 - 4386 Usuel Residenca of Decedent 2 2 F 060 Director Loursbury, NY with the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2864 12cWas Decedent Ever in U.S. Armed Forces? death . Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race American Indien 11. Marital Status Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Merried res 2 No Yes, Give 1 ☐ Yes 2 PNo Specify: Specify. by It Yes, Give Yeer or Dates 3 Widowed 4 Divorced Completed 15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiena. aborer onstru 10 is marked other 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be should be end Mental lasker To George 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Health of Health of Health of Health lefterson, NC Arrie O. Mc Neil Baltimore. 20b. Place of 20c. Location - City or Town, Stete Method of Disposition ant of 6.98 Lansing, NC 28643 4 Donation 5 DOther (Specify) ECHAPEL 21. Signature of Funeral Service Mo-, MD. 2115 23a. Part1. Enter the disease, or complications that caused the deeth. Do not shock, of bear tailure. List only one cause on each line Approximate Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Sepas Examiner Due to (or es a consequenca ot): Examiner The law requires that the death certificete be axecuted Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medicai Due to (or as a consequence ot): 50 ed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the to Yas 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were eutopsy findings evelleble prior to completion of cause ot death? been signal 24e. Wes an eutopsy performed? Completed ate has b 1 Yes ¥⊠ No certificate or Attending Physician: 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatierit 2 ER/Outpetient 3 DOA this funeral 27. Manner of Deeth 28d. Describe how Injury occurred 28e. Date of Injury (Month/Day 28b. Time of Certification: 28c. Injury et Work? After 5 Pending investigation -14 1 ☐ Yes death. 11 Director: / 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t, Location (Street end Number or Rural Route Number, City or Town, Stete) efter ( 4 Homicide n 24 hours the Funeral Dire Hospital 29a. Certifier Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) end manner as stated. edical completely 2 Madical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) and manner stated. (Check only one) To the P within 2

State Registrar 29b. Signature and title of certifier

31. Dete tiled (Month, I

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
D. J. PRADHAN. M.D. 20 CI 32. Registrar's Signetur

D

29c. License number

D15472

20 CROSSROAD DR. OWINGS MILLS 21117 Tel # 410-501-0800

29d. Date signed (Month, Day, Year)

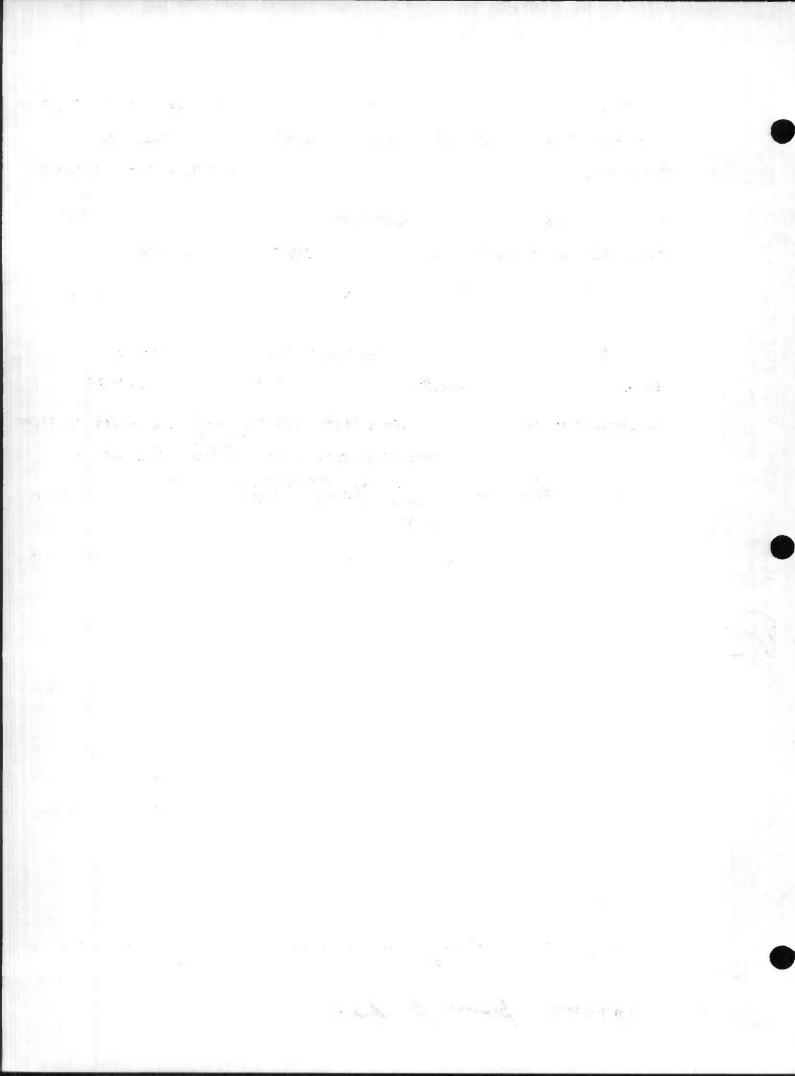
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1	17. Father's I	12 Name (First, Mid	idia, Last)				SALES	ILINIA I			e (First, Middle			•
	ISRA		,,		MIL	LER				TTA			LIPPI	MAN
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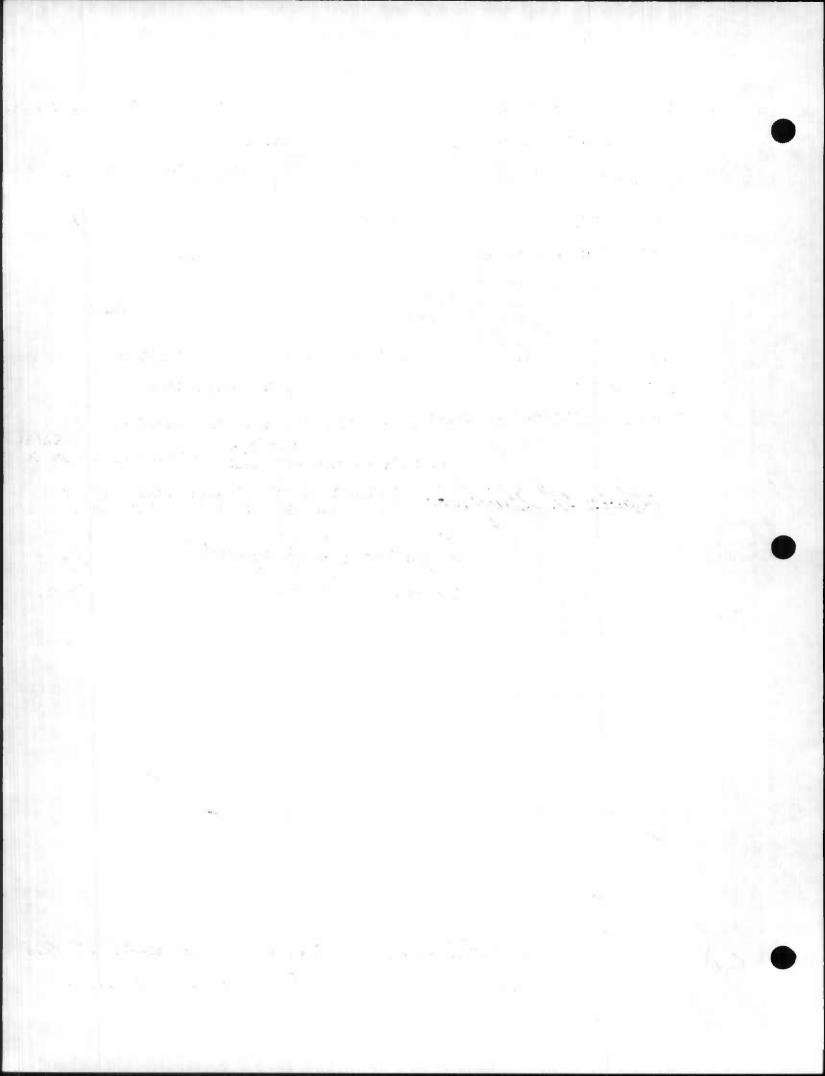
86/11/6

Miller, Bernard



State of Maryland / Department of Health and Mental Hygiene

8569 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth SEPT.12,1998 **Physician** CHARLES WILLIAM MONROE 10:30 P.M /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2114 ASHBURTON STREET BALTIMORE H Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) A PR . 5, 1919 If Under 1 Year 5. Social Security Number 7. Age (in yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** Deys 15M 20F 79 Yrs. VIRGINIA **Director** 225 26 2396 Usual Besidence of Deceder the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or itama 23a or 28a-f ahow Examiner must be notified at 1 Yes 2 No Directo MD. N/A BALTIMORE 10a. Street and Number 10f, Zip Code 10g. Citizen of Whet Country? 2114 ASHBURTON STREET 21216 U.S. OF A. death Funera 12. Was Decedent Ever in U,S. Ayned Forces? 1∆E Yes 2 □ No If Yes, Give 8 / 11/42 Year or Dates:/ 14. Race - American Indien, Bleck, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Never Married 2 Merried 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced BLACK 12/31/45 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) N/A N/ACRANE FOLLOWER STEEL MILL 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) PAUL MONROE BERTHA SCOTT MONROE 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) CYNTHIA CLAIBORNE (DAUGHTER) 2114 ASHBURTON ST. BALTIMORE, MD. 21216 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, State BALTO 9/18/98 Bate 1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) OWINGS MILLS, MD.Co. GARRISON FOREST VET. 21. Signeture neral Service Licensee IS T. GWYNN LEWIS T. GWYNN FUNERAL HOME 21215-6393 dewes 23a. Part1. Enter the disease, or complications that dused the death. Do not enter the mishock, or heart feilure. List only one ceuse of each line. PARK HEIGHTS AVE. BALTO . , MD Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In deeth) Lest Due to (or as e consequence of) Box 68760 Due to (or es e consequence of): 88 USB signed by the e Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en autopsy pertormed? Completed cartificate has b 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No 70 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funerai 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? Certification: 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation eftar death. ector: A 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours eftar Funeral Dire edicai 29a. Certifier 1 Cartifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) end menner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the ceuse(s) and manner stated. (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Balto, MB 21236 -ont 901 E. Deuna Han Vec 31. Date filed (Month, Day, Yeer) 32. Registrar's Signeture 171998 Registrar



#### Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Lest) Day 15 1998 Month Russell G. Morrow September 6:20 PM 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) Manor Care Rossville Rosedale Baltimore if Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) Months 10 M 2□ F Days 82 Yrs. 215-10-2453 Sept 28 1915 MD Usuai Residence of Dacedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1704 Stokesley Rd 21222 USA 14. Race - American Indien. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☑ Married 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade com 16b. Kind of Business/Industry completed) Elemantary/Secondary (0-12) College (1-4or 5+) Lithographer Printing 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Neme (First, Middle, Last) Leon Morrow Nellie Dempsey 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Catherine Morrow /wife 1704 Stokesley Rd Baltimore, MD 21222 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Sept 21 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Remove from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 1998 Catonsville, MD

permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural" any Injury or other traumatic event **Physician** /Medical Examiner

USB

8

page 2 s cartificate has

funeral director,

filled in by

this

After

after death. Director: Aft

24 hours a Hospital

To the Within 2

Division of Vital Records, P.O. Box 68760

or Attending Physician:

**Physician** 

/Medical

Examiner

10a State

MD

Director

Funeral

P

Completed

**Funeral** 

Director

item 27 is marked other than "naturel", or items 23e or 28e-f show other traumatic event, the Medical Evancer must be not led as

the Maryland

with

death

Examiner Sequantially list conditions, if any, leading to immediata ceusa. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last

29b. Signat

ure and title of certifier

30. Name and address of person who complated causa of death (Itam 23a) (Type, Print)

21. Signature of Funeral Service Licensee

23a. Part1. Enter the disa

Immediate Cause (Final diseasa or condition resulting in death)

n or complications that caused the death. The not enter the mode of dying, such as cerdiac or respiratory arrest, lst only ona cause on each line. Approximata Intervel Between Onset and Deeth eumoma Due to (or as a conseque Due to (or es e consequence of):

22. Name and Address of Facility Connelly Funeral Home of Dundalk

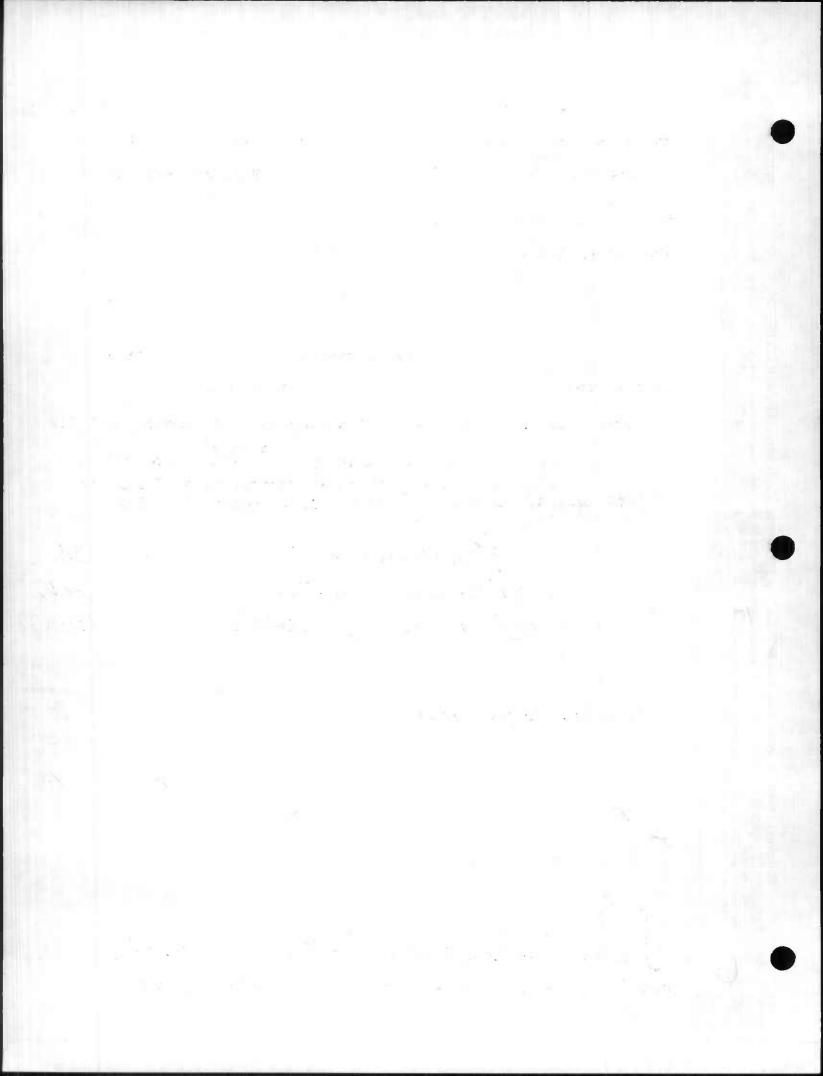
Physician/Medicai Pert il. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveilable prior to completion of causa of death? 24a. Was an eutopsy performed? Completed 2 MNo 20 No 1 Yas 25. Was cesa referred to medicel examinar? Be 26. Place of Death (Check only one) Othar: 4 Residence 6 Other (Specify) To 1 Yes 2No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) 28b. Tima of 5 Panding investigation 1-Naturai 1 Yes 2 - No 2 ☐ Accidant 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homleida 29a. Cartifian 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. Medicai (Check) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Dev. Year)

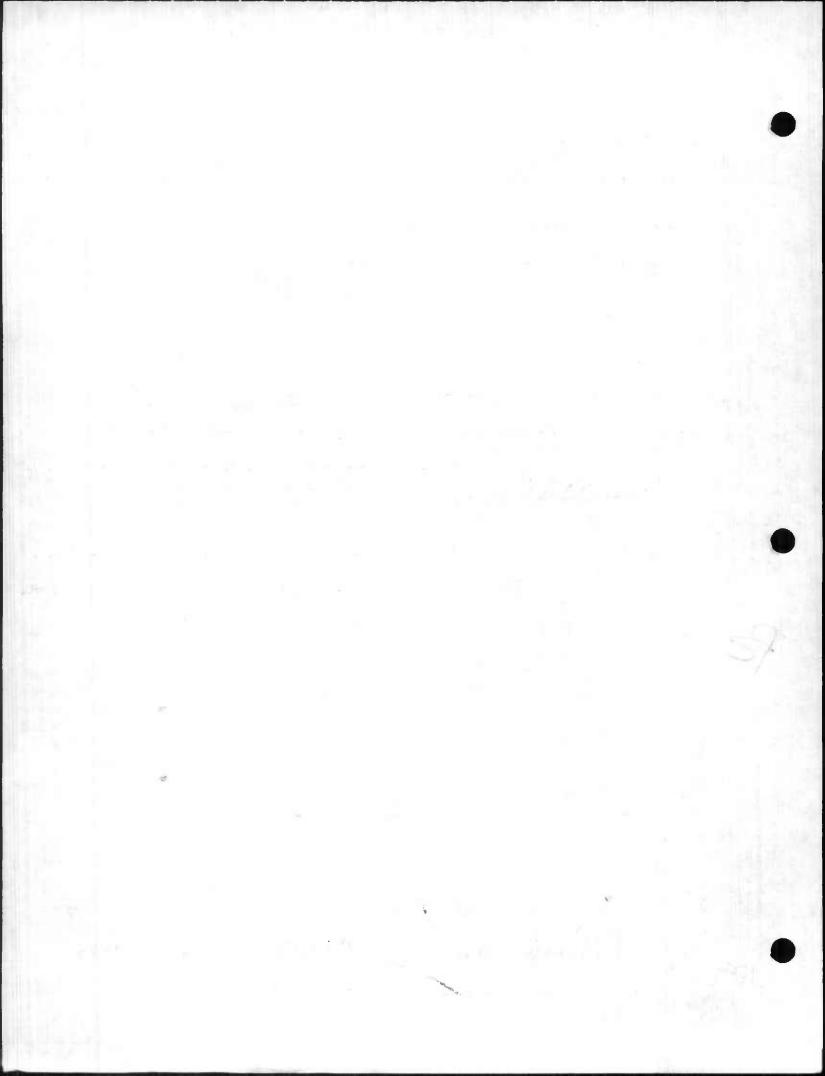
Registrar

Suitas 31. Date filed (Month, Day, Year) 32. Registrar's Signatura SEP 171998



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certi	ficate of	f Death		Re	g. No.		
	1. Decedent's Neme (First, Middle	e, Last)	MO LESSON					2. Date of Deat			3. Time of Death
hysician /Medical	HELEN	М	ROI	BINSO	N			Month	Dey er 16.	Yeer 1998	11:05 A.M.
aicai niner	4e Facility Neme (If not institution	, give street end num				4b. City, To	wn, or Lo	cation of Death	4c. County		11.05 A.M.
miei	Manor Care Rux	ton				Ruxt	on		F	Baltin	more
	5. Social Security Number	6. Sex	7. Age (In yrs. last bir	thday)	If Under 1 Yea	r If Under	24 Hrs.	8. Dete of Birth			
al or	077-03-7882	1 M 2 □ KF			Months Dey	s Hours	Min.	(Month, Dey, July 5,		Coun	lece (State or Foreign try)  N.Y.
	Usuel Residence of Decedent		- 00		1			oury J,	1912		14.1.
	10a. State 10b. County		10c. City, Tow	n or Locat	tion					1	0d. Inside City Limits
Director	Md. Balt	imore	Balti	moro							1 ☐ Yes 2 ☑ No
3	10e. Street and Number	THOLE	Daici	-	10f. Zip Code			10	Og. Citizen of \	Whet Coun	Iry?
0	6902 Marlborous	al- mal			01010						
Funeral	11. Marital Status	12. Wes Dece	dent Ever in U,S.	13. We	21212 s Decedent of	Hispanic Ori	igin? (Spe	city Yes or No-	USA 14. Red	e - Americ	an Indian,
Ē	1 Never Married 2 Marri		2 🔀 No		es, specify Cu			Rican, etc.)	Ble	ck, White,	etc.
6	3 ☑ Widowed 4 ☐ Divorced	If Yes, Giv Yeer or De		1	Yes 2⊠N	o Specify:			Specify	whi	+-
9	15. Decedent		16e.	Deceden	it's Usuel Occ	upation		1	16b. Kind of B		
Completed	(Specify only highes Elementery/Secondary (0-12)	College (1	Acr Ex)	16e. Decedent's Usuel Occu (Give kind of work done life. DO NOT use ratin			t of workii	ng			
EO	1.2	College (1		ome m	aker				Own ho	mo	
Be C	17. Father's Neme (First, Middle,	Last)		7111	unc.I	18. Mothe	er's Neme	(First, Middle, N			
ToB	George		Haviland	1		Alle	na			Stew	ia ret
-	19e. Informant's Neme/Reletionsl	nip (Type, Print)			Address (Stre			I Route Number,	City or Town.		
	Mag Tohun Mills	/3									
	Mrs. JoAnn Mille 20e. Method of Disposition	r/daugnte	20b. Ptece of	Disposition	on (Neme of		a B	altimore Dete 2	20c. Location		
	1 Burial 2 Cremetion		stete		lory or other p						
	4 Donetion 5 Other (Sp		Hillto		rvice			/17/98	Towson	, Md.	21204
	21. Signature of Purreral Service	Decision		Ru	lame end Add ICK TOV	vson Fu	inera	1 Home,	Inc.		
	June 2	CO						on, Md.			
	23a. Part1. Enter the diseese, or shock, or heart failure. List	complications that co	used the death. Do i	not enter t	the mode of d	ying, such es	cardiec o	r respiretory arre	est,	1	Approximate Intervel Between
	Common Date of		0.							1	Onset and Deeth
	Immediete Cause (Final disease or condition		TNE	UN	102	17					DAYS
	resulting in death)	0	Dua to (or as a	conseque	nce of):					1	
Ine		- IN	TERSTITI	AL.	FIB	Rush	S				4 YEARS
Examiner	Sequentially list conditions,	D	Due to (or es a					Hilleri			
EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
Ical	Cause (Disease or injury that initiated events resulting in death) Last	C	Dua lo (or as e o	consequer	nce of):						
Medi	Todaking in Godiny Last									-	
		d									
Physician	Pert II. Other eignificant conditio	ns contributing to de	ath but not resulting in	the unde	orlying cause	given in Pert I	),	23b. Did tobacco use contribute to			the cause of death?
hy				esulting in the underlying cause given in Pert I.							bably 4 Unknown
by P											
B								24a. Wes er		24b. We	ere eutopsy findings ailable prior to
Completed								perform	ned?	CO	mpletion of cause deeth?
E											
	OF Was once of such to the such							1 Ye		1	Yes 2□ No
Be C	25. Wes case referred to medical examiner?	Hospitel:			- 10	ther _		(Check only on			
- L	1 Yes 2 No 27. Manner of Death	1 1 1	patient 2 ER/Ou		3LI DOA	4 ES IV		ne 5 Reside			y)
lon	1 Netural 5 Pending			Time of njury	28c. In			28d. Describe ho	w injury occur	Del	
cat	2 Accident investig	of he	46-1			Yes 2		206 1			15-4-1
Certification:	4 Homicide determi	ned 200. Place	of tnjury - At home, fe eg, etc. <i>(Specify)</i>	rm, street	, fectory, offic	0	2	28f. Location (Sti City or Town		per or Rura	i Houte Number,
edical	(Check only 2 Medical E	Physician: To the le	pest of my knowledge sis of examinetion en	deeth od	courred at the	time, date en	d plece, e	and due to the ce	use(s) and me	and due to	ated.
	one)	end menn	er steted.	- OI 1114931	ganori, arrilly	ориноп, име	ar occurre	ou at the time, Of	no one piece,	and due to	, and oadso(s)
2	29b. Signature end title of certifier	1.				nse number		25	ed. Dete signe	d (Month,	Dey, Year)
	1110	21/4	MD		0.	13319	7	5	EDT 1	6 19	88
	30. Name and address of person v	who completed cause	of death (Item 23a) (	(Type, Prir	nt)						•
)						con M	14 2	1204			
ate	Nathan M. Roser 31. Date filed (Month, Dey, Year)	32 Be	7600 OS	La D	TOW	son, M	Ma. Z	1204			
strar	SEP 17	1998	Strawn 1	D.	span	KS					

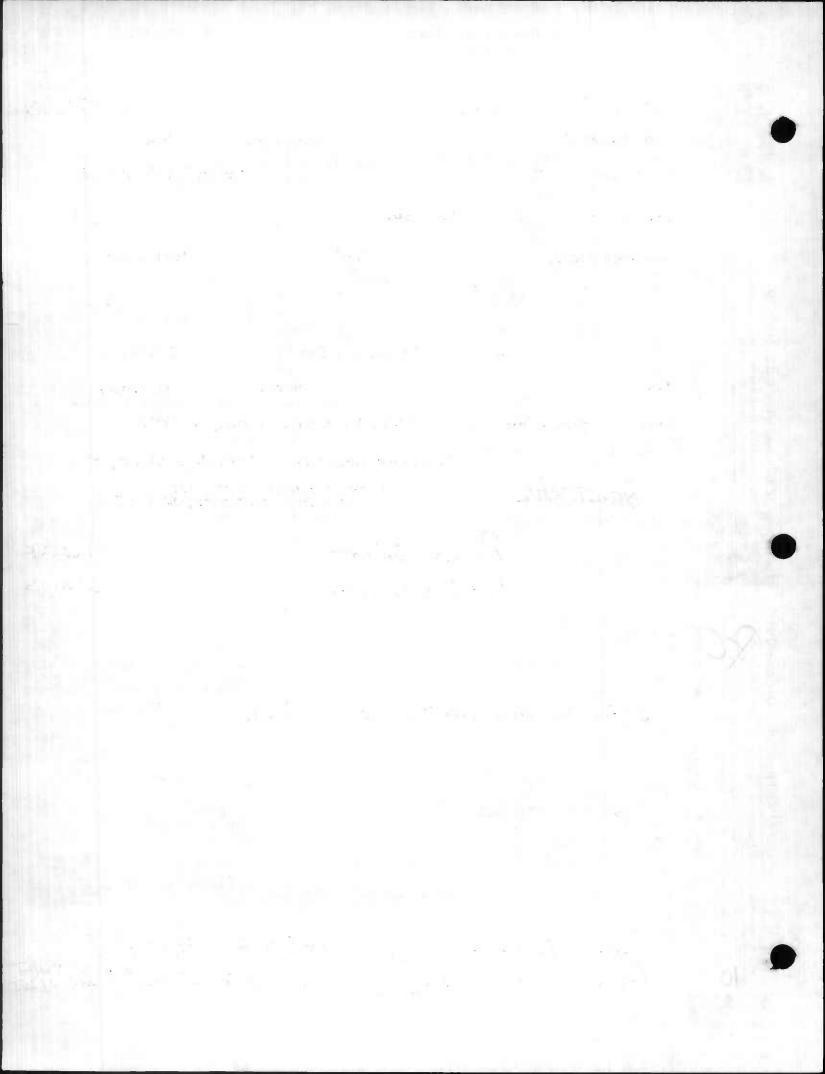


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Stanislau Kembski /Medical 4c. County of Death 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death Examiner Sinai Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Yrs. 213-34-3069 101 October 9, 1896 **Director** Poland Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f show traumetic event, the Medical Examiner must be not that at 1 Yes 2 □ No N/A Maryland Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1404 Park Avenue 21217 United States Funeral filed within 72 hours efter death 12. Wes Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 X No Specity: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry permit. Pages 1 end 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'na any injury or other traumatic event, in a Media page. Coilege (1-4or 5+) Elementary/Secondary (0-12) Portrait Artist Private 18. Mother's Name (First, Middle, Malden Sumame) 17. Father's Neme (First, Middle, Last) Unknown Madeline (Unknown) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Norman F. Spector/Step-son 605 Hastings Road Towson, MD 21286 20a. Method of Disposition
1 ☐ Burial 2 ACremation 3 ☐ Removal from State 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Crematory 9-16-98 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Home, Inc. 6500 York Road Baltimore, MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** PNERMONIA /Medical Immediate Cause (Finel disease or condition resulting in death) IWEK Examiner Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last and Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) **Physician/M** Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? LUNG DIS CHRONIC OBSTRUCTIVE 1 Yes 28 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate ! 25 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: 1 ■ Inpatient 2 □ ER/Outpatlent 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 25 No 24 hours after death.

Funerel Director: After this funeral 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? Certification: 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) and manner as stated. 29a. Certifier edical completely 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and pleca, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signatur en 29d. Date signed (Month, Dey, Year) ur 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 4200 38 GREENTREE RD 10 NISSIAN and 31. Date filed (Month, Day, Year) 32. Registrar's Signature 171998 SEP

DHMH 16 Rav 6/95

Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month MARIE SHANTA SEPT. 15, 1998 6:00 A. M. 4a Facility Name (If not Institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death EASTPOINT REHABILITATION & NURSING CENTER BALTIMORE BALTIMORE If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1□M 2XF 212-01-9487 AUG. MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XXYes 2 No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 712 N. CURLEY STREET 21205 u. s. Α. 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, Whita, etc. 11. Merital Stetus 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 🖾 Married 1 Yes 2 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9TH GRADE SEAMSTRESS CLOTHING STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) STANISLAUS KLAPKA UNKNOWN ANNA 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALBERT FRANK SHANTA (HUSBAND) 712 N. CURLEY STREET, BALTIMORE, MARYLAND 21205 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) BOHEMIAN NATIONAL 9/17/98 BALTIMORE, MARYLAND 21. Signature of Funeral Se 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME INC. BREHMS 3331 LANE, BALTIMORE, MARYLAND 21213 23a. Part1. Enter the disertie, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. etastatic Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that Initiated events resulting in death) Last to (0 Pert II. Other significant conditions contributing to death but not resulting in the unserlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24a. Wes an eutopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Homa 5 Residence 6 Other (Specify)

Examiner

P.O. Box

Records,

Division of Vital

Physician

/Medical

**Physician** 

/Medical

**Examiner** 

10a. Stete

Directo

Funeral

Completed

**Funeral** 

**Director** 

ò 238

altimore, Maryland 21215-0020

Mental 9

Pages 1 and 2 should nant of Health and Man

Department of Health a Important: If Item 27 is any injury or other trau

The law requires that the deeth ce certificate or Attending Physician: this

Physician/Medical Examiner by Completed Be

Medical Certification: To 24 hours after death. completely filled in Hospital

To the Vithin 2

State Registrar

1 Yes 2 No 27. Manner of Deeth 5 Pending Natural 2 Accident 3 Suicide

29b. Signeture and title of certifier

4 ☐ Homicide

29a. Certifier (Check only one) Investigetion

6 Could not be determined

28e. Date of Injury (Month, Day Year) 28b. Time of

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stele)

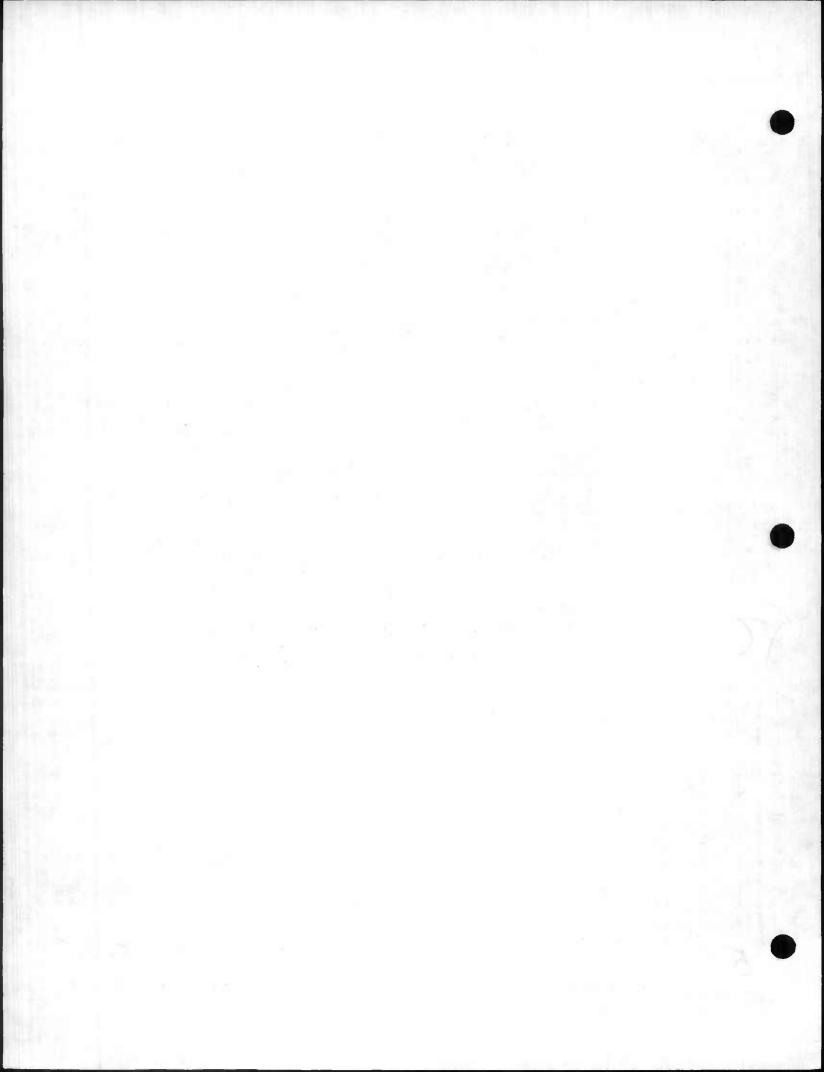
Are Baltimore Md 2122

10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

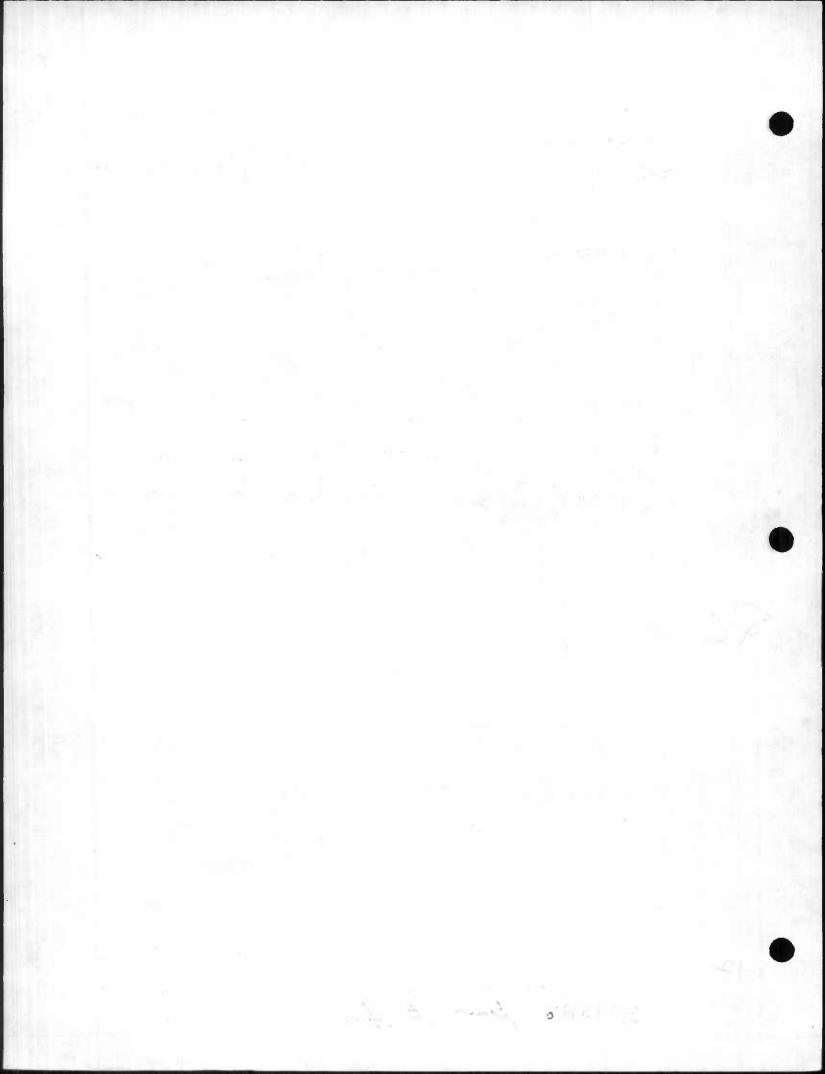
30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signeture 171998 SEP

AMAMA



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth Month **Physician** erman /Medical 4e Fecility 4b. City, Town, or Location of Death Neme (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE NORTHWEST HOSPITAL CENTER RANDALLSTOWN If Under 1 Yaar | If Under 24 Hrs. 8. Data of Birth (Month, Day, Ye SEPT. 3, Birthplaca (Stata or Foreign Country)
 MARYLAND 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Year) 1913 Deys Months Hours Min. 1 M 2 F Yrs. 85 Director 220-24-7155 Usual Rasidence of Dacedant Maryland 10b. County 10a Stata 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f show aminer must be notified at MD N/A BALTIMORE 1 Yas 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21209 USA 6614 CHIPPEWA DR. death Funeral 12. Wes Dacedent Evar in U,S. Armed Forcas? 14. Race - Amarican Indien, Black, Whita, atc. 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ Xyo If Yes, Giva Baltimore, Maryland 21215-0020 WHITE 1 ☐ Yas 2 No Specify: Specify þ 3 Widowed 4 Divorced Yeer or Detes "natural". Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry Hygiena. Elementery/Secondery (0-12) Collega (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien, Important: if item 27 is marked other that any follury or other traumatic event, the PAGE. OWNER GROCERY 12 17. Father's Nema (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumema) Be ROSE FRANKIL SAMUEL SMOLKIN 2 19e. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) BELLE SMOLKIN (WIFE) 6614 CHIPPEWA DR. BALTIMORE, MD 21209 20a. Mathod of Disposition 20b. Place of Disposition (Nema of cematary, crametory or other place) 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Ramoval from Stata OHR KNESSETH ISRAEL ANSHE SFARD 9/16/98 ROSEDALE, MD 4 Donation 5 Othar (Specify) SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 Part 1. Enter the diseasa, or complications that aused the deeth. Do not antar tha moda of dying, such as cerdiec or raspiretory errest, shock, or heart failura. List only one care than the deeth. Approximete Intarval Batween Onset and Death **Physician** Immedieta Causa (Finel diseasa or condition rasulting in death) /Medical Examiner Due to (or es a consequance of) Sequantially list conditions, if any, laading to immediata ceusa. Entar Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Box 68760 Due to (or as e consequance of): Physician/Med attending i P.O. Pert II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Records, p 24b. Were eutopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 2 No certificate 1 Yas 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: director, Be 25. Wes cesa rafarred to medicel axaminar? 26. Place of Death (Check only ona) Hospital: 1 Dinpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No Certification: To this 28a. Deta of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? After 1 Watural 5 Pending death. 1 ☐ Yas 2 ☐ No 2 Accidant invastigation Director: 6 Could not be datarmined 3 Suicida 28a. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, Stata) 24 hours after de Funeral Direct Metaly filled in by 4 Homicida Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian edical (Check only one) To the Pwithin 2 29b. Signature end title of certifian 29c. License number 29d. Data signed (Month, Day, Year) 3 30. Nama and address of person who completed ceusa of death (Item 23a) (Type, Print) Prt/11 SEP 1 5 19 32. Registrar's Signatura State 5 1998 Registrar



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month SEPT 12, 1998 MOLLYE SHOFER 6:08pm 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street and number) NORTH OAKS HEALTH CENTER BALTIMORE BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day Year) | OCT 11, 1907 Birthplace (State or Foraign Country) NEW YORK 5. Social Security Number 7. Age (In yrs. last birthday) 1□ M 2√ F 90 Yrs. 218-22-5057 Usuel Rasidence of Decedent 10e Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No MARYLAND BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? Street end Number 725 MT. WILSON LANE, APT. 212 21208 USA 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Giva X Year or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 □ Divorced WHITE 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) PROPRIETOR BICYCLES 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) LESTER BIRNBAUM MIRIAM SILVERMAN 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19e. Informant's Neme/Relationship (Type, Print) 19 PHLOX CIRCLE, APT. D OWINGS MILLS, MD 21117 MRS. MIRIAM BENNETT (DAUGHTER) 20b. Placa of Disposition (Name of cametary, cramatory or other plece) Dete 20c. Location - City or Town, Stete 20e. Mathod of Disposition 1X Buriel 2 ☐ Cremetion 3 ☐ Removal from Stata (ANSHE EMUNAH) AITZ CHAIM 9-14-1998 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23e. Pert1. Enter the diseese, or complications that caused the death. Do not enter tha moda of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Preumonia Immediete Ceuse (Finel diseese or condition rasulting in daath) Week Due to (or es e consequenca of): 2 weeks Sequentielly list conditions, if eny, leeding to immedieta causa. Entar Underlying Cause (Disaase or Injury that initiated avents resulting in daath) Lest Due to (or es e consequence of): Dua to (or as e consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the causa of death? 1 Yes 2 No 3 Probably 4 M Unknown Vancular 24b. Were eutopsy findings available prior to 24e. Wes an eutopsy performed? completion of cause of daeth? 1 Yes 2 No 1 ☐ Yas 2 ☐ No

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point. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Decement of Heelth and Mental hygiena. Insportant if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantine count to notified a

Baltimore, Maryland 21215-0020

nis cartificata has b il director, paga 2 si Hospital or Attending Physicien: this funeral death. efter deatl Director: in by To the Hospital or within 24 hours eff To the Funerel Di completaly filled in

Division of Vital Records, P.O. Box 68760

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25. Wes case referred to medical axaminar? 26. Place of Daath (Chack only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida 29a. Certifier

1 Certifying Physician: To the best of my knowledga, deeth occurred at the time, dete end plece, and dua to tha cause(s) and mennar as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) end menner stated.

and little of certifier 29b. Sidnat

29c, Licensa number 038675 29d. Data signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

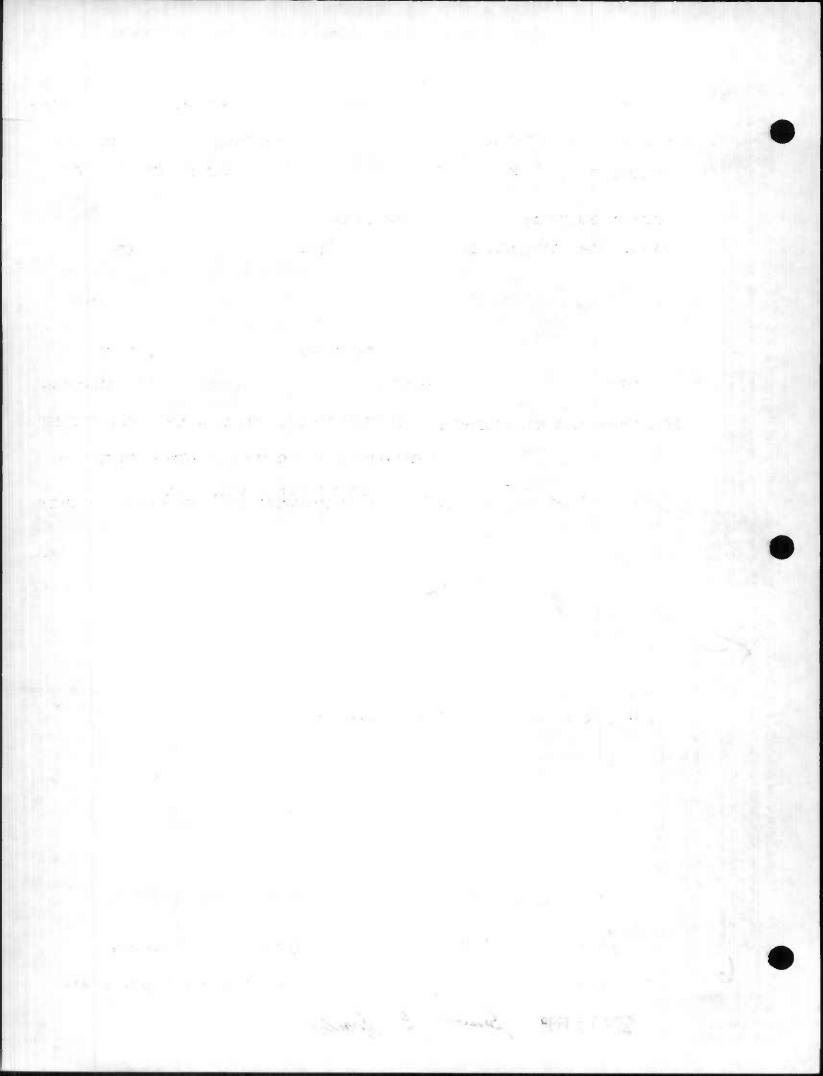
JUEL MESHULAM 1147 HANOVER ST BALTIMORE MD 21230

32. Registrer's Signeture

MD

Registrar

31. Dete filed (Month, Day, Year)



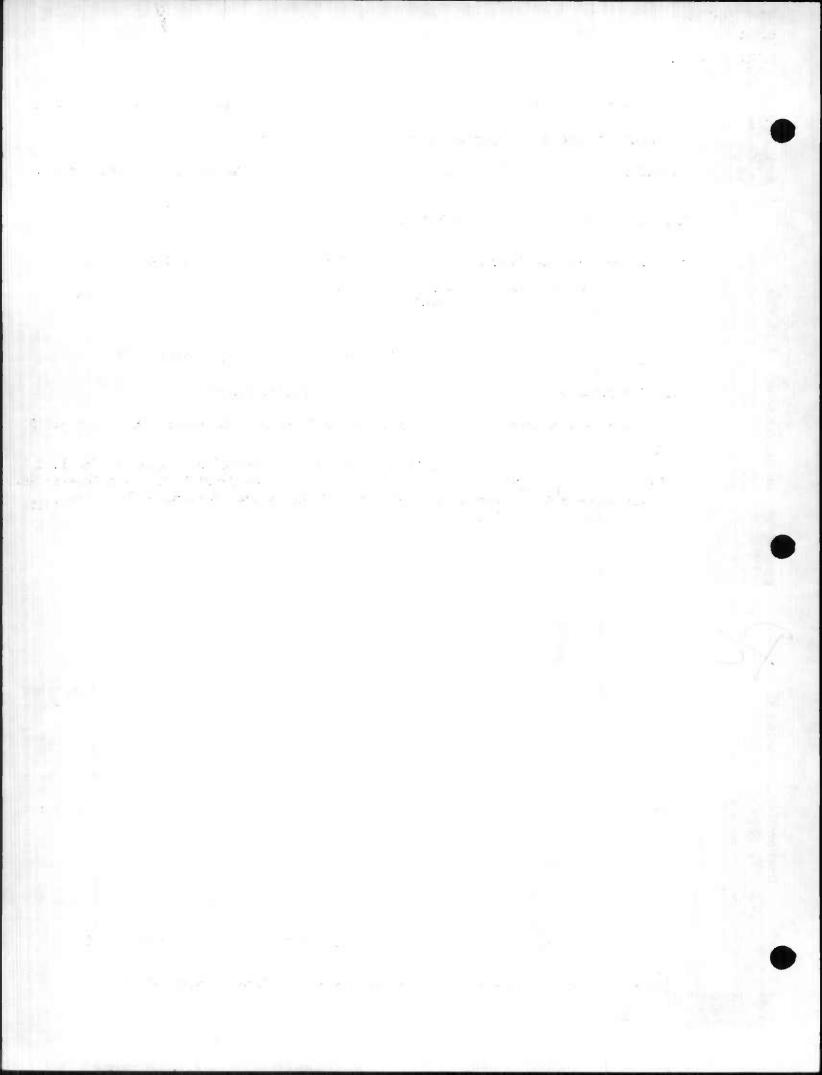
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Sept. 15, 1998 6:40 AM Lucile A. Shaver /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Neme (If not institution, give street end number) **Examiner** Anne Arundel Annapolis Nursing Center Annapolis | Frunder 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Manth. Day, Year) | 9. Birthplece (State or Foreign Months | Deys | Hours | Min. | April 6, 1909 | Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 XF 214-30-4793 89 Yrs. Director Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "naturel", or items 23a or 28a-f show other traumstic avent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Md. Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 900 Van Buren St. 21403 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes ≥ 2 No if Yes, Give Yeer or Dates: 14. Race - American Indian. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bieck, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White p 3⊠ Widowed 4 □ Divorcad Completed 16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) filed within 7 Hygiena. permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiena. Important: If flam 27 is marked other than any Injury or other traumatic avent Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Neme (First, Middle, Malden Sumeme) 17. Father's Name (First, Middle, Last) Be Bertha Barnsley Robert F. Sanford 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Annapolis, Maryland 21401-2319 Mrs. Cynthia Haworth/Grandchild 657 Genessee St. 20b. Pieca of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 ☐ Burial 2 X Cremetion 3 ☐ Removal from State 9/17/98 Hilltop Service Corp. Towson, Maryland 4 □ Donetion 5 □ Other (Specify) 22. Name end Address of Fecility Ruck Towson Funeral Home, Inc. 21. Signeture of Funeral Servica Licensee 1050 York Road Towson, Maryland 21204 23a. Pert1. Enter the disease, or compositions, or heart failure. List physical plicetions that causes the death. Do not enter the mode of dying, such as cardiac or respiretory errest, one cause on each ine. Approximete Intervel Between Onset and Deeth **Physician** /Medicai Immediate Cause (Final diseese or condition resulting in deeth) Examiner Due to Examiner burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequença of) Physician/Medicai thet initieted events resulting in death) Lest Due to (or as a consequence of) Box Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? Division of Vital Records, P.O. the 3 Probably 4 Vunknown 1 Tyes 2 No g 8 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? has page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No cartificate Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) To 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA After this funeral 28e. Dale of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury ef Work? 28d. Describe how injury occurred 28b. Time of Certification: Attending 1 Neturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation or Attend after death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Pieca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es stated.

2 Medical Examinar: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner stated. 29a. Certifier (Check only one) Medical completely To the To the I 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and titig of certific person who completed cause of deeth (Item 25a) (Type, Print) Hunzpolished. hman, M.
32. Registrar's Signeture State 1998 epera Registrar

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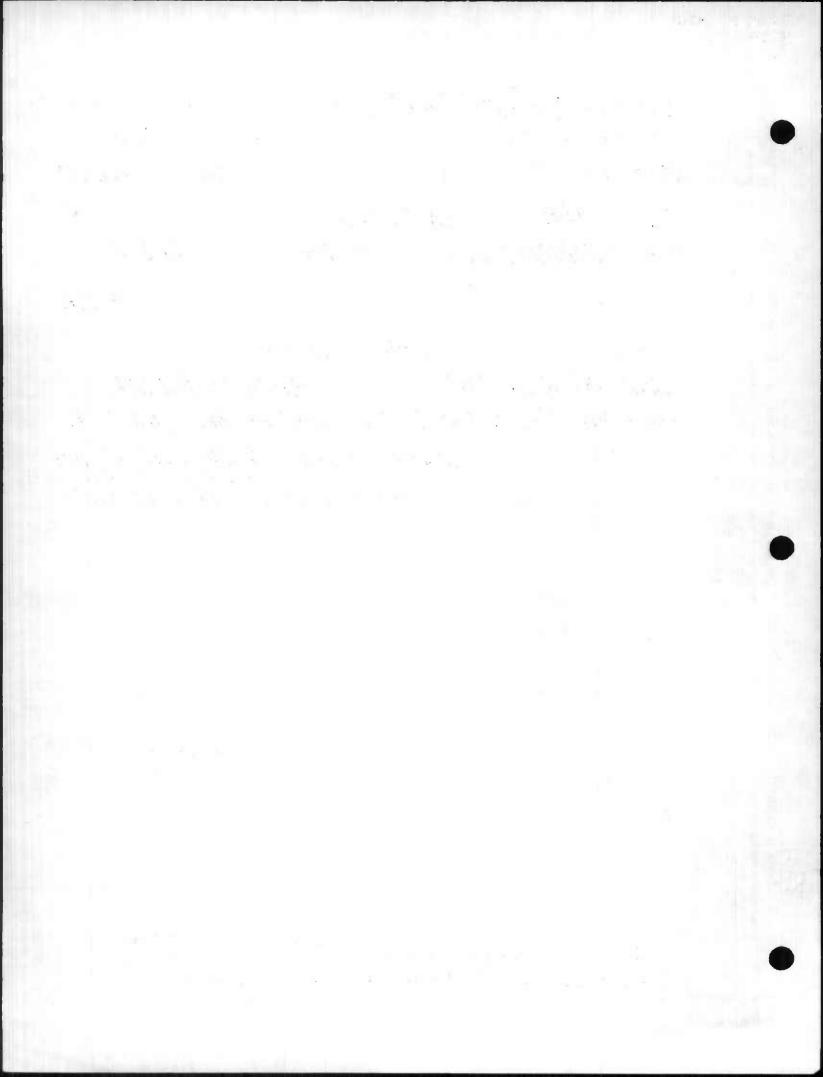
	ITEMS: #23	PART I, 27, 28A-F PER M		WR.	Certifica	ate of	Death	l o Data of	Reg. No.		2 Time of Dooth
	Physician	Decedent's Name (First, Middle, Last,     Zanda Ann Stuart						2. Date of Month	Day	Yeer	3. Time of Death
	/Medical						4h Cihi Tour	SEPT		98 ty of Death	1;46 PM
	Examiner	4a Facility Name (If not Institution, give REAR OF 3600 BI		7/1/27	ת זוכי		BALTI		40. 0000	ty OI Death	
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	r freme 23 rher must	11. Marital Status	12. Was Decedent Ever in		13. Was Dec		Hispanic Origin	n? (Specify Yes or Puerto Rican, etc.)	No- 14. R	ace - Ameri	ican Indien,
21215-0020	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ØYes 2 No I	1/80- 3/81			Specify:	gorto riisan, ster,	Spec	73.1	ack
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Maryland	d d 2	Nellie Walker / Mo									and 21215
re,	- SEE	20a. Method of Disposition		Place of	Disposition (A	leme of	cal	Date	20c. Location		
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sio	Attending r death. ector: Alle by the fune	2 Accident Investigation 3 Suicide 6 A Could not be					Yes 2 X N		UNKNOW		
Division	and and	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe FOUND IN A W	ecify)		ory, office		City or	n (Street end Nur Town, State) R ALTIMORE, M	EAR OF ARYLAN	rai Route Number 3600 WOODLANI D
-	# # # P P P		sician: To the best of my k	nowledge	death occurre			plece, end due to t	he ceuse(s) and	menner as	stated.
	within 24 hours within 24 hours To the Funer completely fit	one)	ner: On the basis of examinant manner stated.	motion en			Elizabili	occurred at the tin			
	To Tage	29b. Signature and title of certifier	W.		1		se number		29d. Date sign		the state of the s
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		30. Name and address of person who co	empleted cause of daeth (I			tree	t, Bali	timore, M	aryland	21201	
	State Registrar	31. Date filed (Month, Dey, Year) SEP 1 7 1998	32 Registrar's Sig			ocks					



EDWARD E. SMITH 98-5356-510

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	Examiner		ility Neme (If not institution, gh 3 MARTINGALE A			4b. City, Town, or BALTIMO		4c. Coupty	of Deeth	
	Funeral Director	220	-64-3347	Sex 7. Age (In yrs.	Jest birthday) If Und Month	er 1 Yeer   If Under 24 Hrs s Deys Hours Min		5,196/	9. Birthplece (State or MACYLAND)	Foreign
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	iter death with the Marrier as 23a or 28a-1 s where must be notified Funeral Director	10e. Str	B MARTIN	GALE AVE.	6	ip Code 129		10g. Citizen of t	A.	
5-0020	urs after	3□	ritel Status Never Merried 2☐ Married Widowed 4 ☑Divorced	12. Was Decedent Ever in to Armed Forces?  1 ☐ Yes 2 M No If Yes, Give Yeer or Detes:		edent of Hispenic Origin? (Secify Cuben, Mexicen, Puer 2 No Specify:	Specify Yes or No to Rican, etc.)	- 14. Rac Blee Specify	e - American Indien, ck, White, etc.	
21215-0	within and the state of the sta	Elem	15. Decedent's E (Specify only highest greentacy/Secondary (0-12)	ducetion ede completed) College (1-4or 5+)	16e. Decedent's Us (Give kind of v tife, PO NOT	uel Occupetion york done during most of wo use retired)  S MAKER	orking	Beda	usiness/industry	
Maryland	Demit. Pages 1 and 2 should be filed Department of Health and Mental Hygis important: If item 27 is marked other important: other traumatic event, and follows.	17. Fatt	ner's Neme (First, Middle, Last OMAS JUFFE)	SON Smith	6	HENR	me (First, Middle,	BONN	ER	
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Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once.	10	Burial 2 Cremetion 3 Donetion 5 Other (Special	Removel from State ME	TRU CREM	ATORY	9/19/98	CATUNSV	ILLE, MD	to and
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, P.O.	i that the death cert ned by the attending e detached for use i y Physician/M		NARCOTISM	of the desired to the total of	saturg in the enderlying	, sauda giran in rain.			3□Probably 4⊠t	
sion of Vital Records,	The lew requires that has been signe, page 2 should be d						perfo	an eutopsy omed? ECTION	24b. Were eutopsy fi evaileble prior to completion of co of death?	0
al F	defant: The cartificate inector, pag							Yes 2XXVo	1 ☐ Yes 2 ☐	No
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fon of	th. After the formal at funeral a	-	nner of Deeth   Naturel 5   Pending     Accident   Investigatio	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?		how injury occur		
DIVIS DIVIS	To the Mospital or Attending P within 24 hours after death. To the Futered Director After completely filled in by the tunen Medical Certification:	3 4	Sulcide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Speci	nome, ferm, street, fect ify)	ory, office	28f. Location ( City or To		ber or Rural Route Numi	ber,
1	To the Mouptial or within 24 hours ath To the Funeral Dis completely filled in Medical Cer	29e. Ce		nyelclen: To the best of my kno niner: On the basis of exemina end menner steted.	owledge, death occurre etion end/or Investigetion	d et the time, date end piac on, in my opinion, deeth occ	e, end due to the urred at the time,	ceuse(s) end modete and piece,	enner es stated. end due to the ceuse(s)	)
	wethin 2 wethin 2 To the comple	29b. Sig	gneture end title of certifier	A	2	9c. License number O.C.M.E.			od (Month, Dey, Year) BER 11, 1998	8
		30. Nan	Atyph A	Completed cause of death (Me						
		St	ephen Radentz			eet, Baltimon	re, Mary	land 212	201	
	State	31. Dete	e filed (Month, Day Year)	32. Registrer's Sign	9. Inc.	1.1				



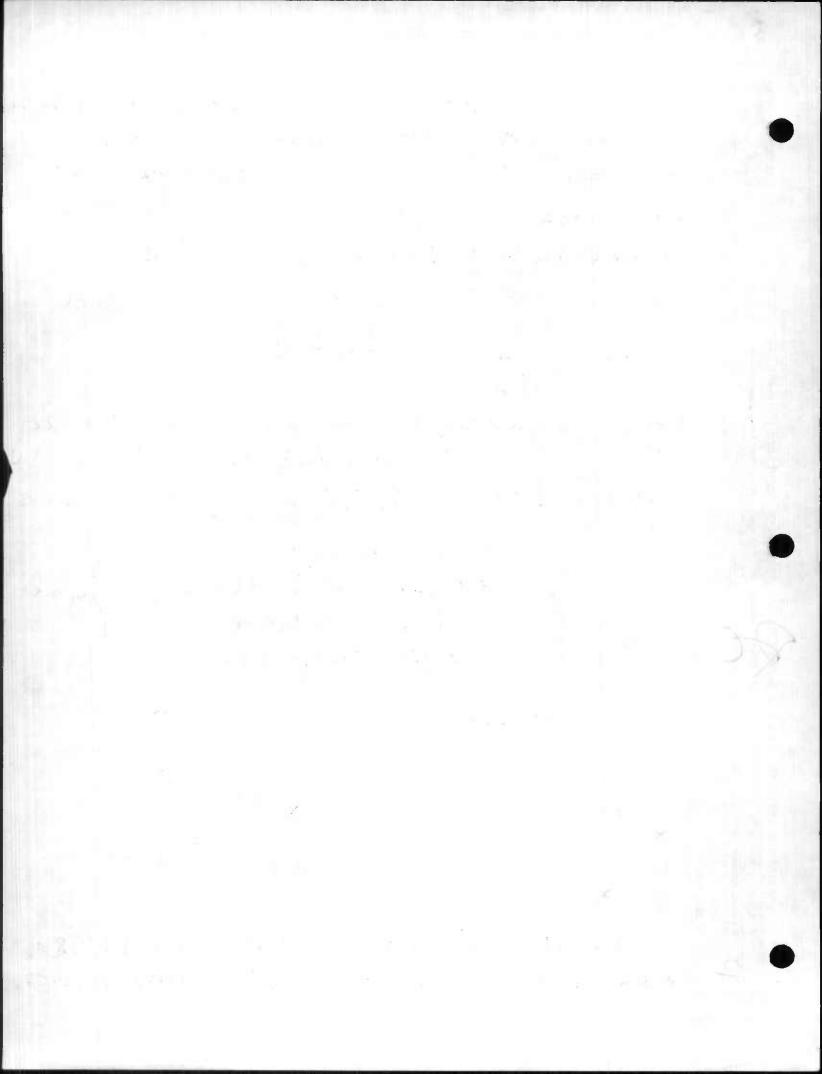
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Vaughn **Physician** 30 pm en H2rin 0 98 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner ndprior Monx MD) Baltonso USA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M 2 H Yrs. 215-16-035 **Director** Usuel Residence of Decedent the Marylen 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours efter deeth with the Maryle th end Mental Hygiene. It marked other than "natural", or itema 23a or 28a-f show traumatic event, the belief Education than to notified at traumatic event, n AG 1 Tes 2 No Director HIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Garden AZ Funeral 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ Mo Specify: þ 3 ₩idowed 4 Divorced lac Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 4th ACA DMES +16 TOME 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown unknown 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health end Important: If Item 27 is in any injury or other traun pace. Deen da Young - Grad daug 20e. Method of Disposition 2 Demovel from State 4438 (sed or bardies 20c. Location - City or Town, Stete 206. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 □ Cremation 3 □ Removel from State 9-18.98 Kandallstown Mo 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home West ING Jarch Fungral 23a. Per 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shelck, or heart value. List only one ceuse on each line. Batto nd 21215 Approximete tnterval Between Onset end Death **Physician** /Medical Immediate Ceuse (Final morran disease or condition resulting in death) **Examiner** Due to (or as e consequence of) 25 SV3 Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part t. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown PO16. à 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 certificate has 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 100 27. Manner of Death urieral 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Attor Certification: 5 Pending 2 No investigetion 1 Yes 2 Accident after death Director: 6 ☐ Could not be Location (Street and City or Town, State) 3 ☐ Suicide and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 8 24 hours Funeral 29a. Certifier Certifying Phyaictan: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner as stated. edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the To the 29c. License number D00 52 f 72 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Batimorealdi 501

DHMH 16 Rev 6/95

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death	Reg. No.
	2. Date of Death

3. Time of Death

0510 AM

9. Birthplace (State or Foreign Virginia

White

24179

Approximete Intervai Between Onset and Deeth

24b. Were autopsy findings evallable prior to completion of ceuse of death?

No 2 No

10d Inside City Limits

1 Yes XX No

			Cei	rtificate of	f Death		Re	g. No.	5 %
Physician /Medical	Decedent's Name (First, Middent Rober		ilson, Jr.				2. Date of Death Month AUGUST		998
Examiner	4a Facility Name (If not institution 646 LAW STREET		umber)		4b. City, Tow ABERDER		ocation of Death	4c. Coun	ty of Death
Funeral Director	5. Sociat Security Number 229-80-7711	6. Sex XXM 2□ F	7. Age (In yrs. last birthdey) 43 Yrs.	If Under 1 Yea Months Day		4 Hrs. Min.	8. Dete of Birth (Month, Dey, Sept. 2	Year) , 1954	9. Birth Cou VI

To the To the To the

Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b County 28a-f show 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at Director Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 646 Law Street 21001 United States of America Funeral death permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: if flem 27 is marked other than any injury or other transmitted. 12. Was Decedent Ever in U,S. Armed Forces? 1 (2) Yes 2 □ No If Yes, Give Year or Dates: 17 Yrs 14. Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Laborer Woodworking 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Robert Hale Wilson Sr. Frances Ann Greer 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a, informant's Name/Relationship (Type, Print) 225 Cameron Drive Robert H. Wilson Sr. (Father) Vinton, Virginia 20h. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, Stete Simpson-Tharp Cremation 1 ☐ Buriat 2 X Cremetion 3 ☐ Removei from State 8/28/98 4 ☐ Donation 5 ☐ Other (Specify) Center Roanoke, Virginia 21 Signature of Euneral Service Licensee 22. Name end Address of Facility Simpson-Tharp Funeral Home 5160 Peters Creek Road 101 Roanoke, VA 24019 23a Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, of heart fallure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) Contact Gunshot Wound of Head Examiner Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): and be exec 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24a. Was an autopsy peed antial has page 2 1 No 2 No certificate funeral director, Be 25. Was cese referred to medicat examiner? 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) XXYes 2 No To this 28b. Time of Injury M Dete of Injury (Month, Dey Certification: 27. Menner of Deeth 28d. Describe how injury occurred 28c. Injury at Work? self in flicted gunshot wound After 5 Pending investigation 1 Naturel i or Attending satter death. I Director: Aft 1 Yes 2 No 8/26/98 2 Accident 3 Sulcide 4 ☐ Homicide 6 Could not be determined 28e. Place of tnjury - At home, farm, street, fectory, office building, etc. (Specify) 8f. Location (Street and Number or Rural Route Number, City or Town, State) (46 Low St Aberdan, Ad filled in by Hospital c 24 hours at Funeral D hame 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

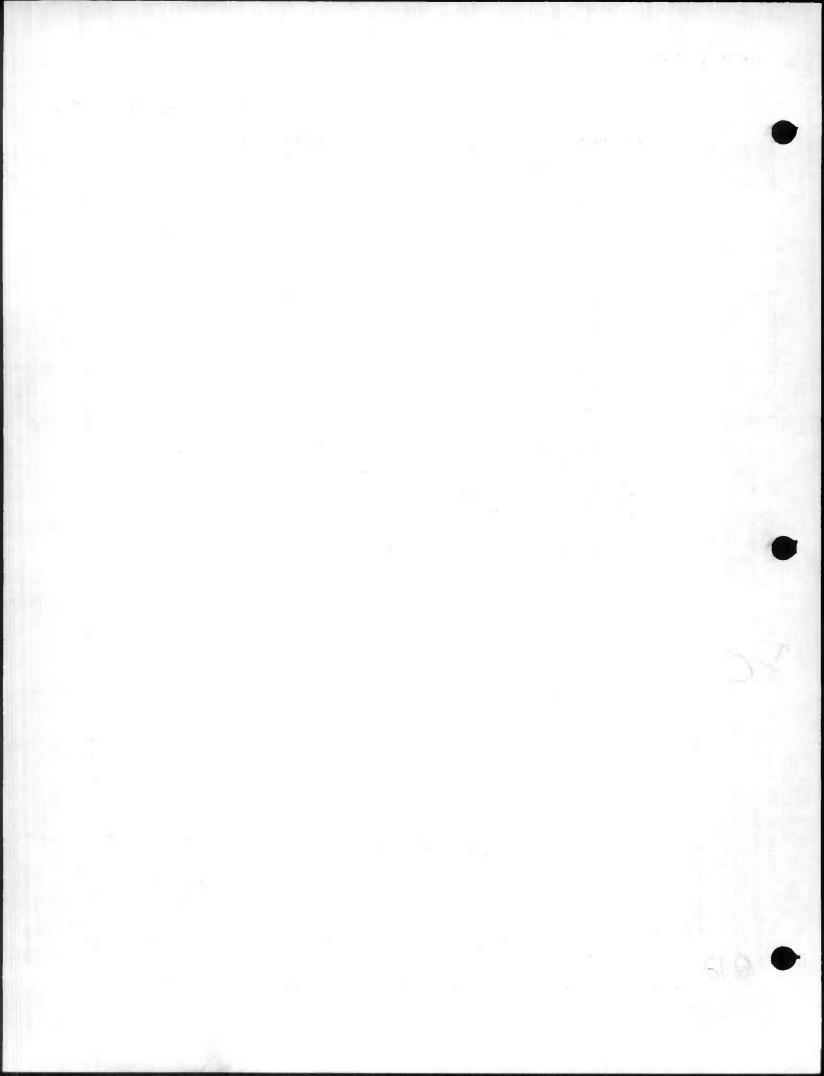
XX Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

29d. Date signed (Month, Dey, Year) 29c. License number AUGUST 26, 1998 OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

Dennis Chute M.D. State Registrar

29b. Signeture and title of certifier

31. Dete filed (Month, Day, Year) 32. Registrar's Signeture SEP 1 7 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** WOOTERS Month Yaai BELVIA M 5:25 PM SEP 12 1998 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SAMARITAN HOSPITAL 'N/A if Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 11-14-1912 If Under 1 Year Months Days 9. Birthplaca (Stata or Foraign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** 10 M 20 F Days Director 218-18-5744 Georgia Usual Residence of Decedant permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Deportment of Health and Mental Hygiene. Important: If lean 27 le marked other than "natural", or itams 23a or 28a-f show any injury or other traumstic event, the Medical Example must be notified at 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Director Maryland N/A Baltimore 10e. Straat and Number 10f. Zip Coda 10g. Citizan of Whet Country? U.S.A. Room 206 21214 4700 Harford Road Funeral 11. Maritai Status 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 1 □ Navar Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: þ 3 Widowed 4 □ Divorced Specify White Completed 16a. Decedant's Usuai Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacadant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collage (1-4or 5+) 9 Years Waitress Restaurant 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Be 2 Unknown Unknown 19a. informant's Name/Raiatlonship (Type, Print) 19b. Mailing Address (Straet and Numbar or Rural Routa Number, City or Town, State, Zip Coda) Nell Patterson / Sister 126 Glenfield Lane, Hendersonville, NC 20b. Placa of Disposition (Nama of cematery, crematory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 9/16/98 Suches, GA Pleasent #2 Baptist Cem. 21. Signatura et Funeța Sarvice Licensaa 22. Nama and Addrass of Facility Leonard J. Ruck, Inc. Wayne Osterling 5305 Harford Road Baltimore, Maryland 23a. Part1. Inter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heet failure. List only one cause on each line. 21214 Approximata Intervel Between Onsat and Death **Physician** /Medical Immediata Causa (Finai disaasa or condition rasulting in daath) 2 DAYS ASPIRATION PNEUMONIA Examiner Due to (or es e consequance of) Examiner lician end buriel-transit Sequantially list conditions, if any, leading to immadiata cause. Entar Undarlying Causa (Disaasa or injury that initiated events Dua to (or as a consequance of) Physician/Medical that initiated events rasulting in deeth) Last Dua to (or as a consaquanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Ovarian tumos Records, by 24b. Were autopsy findings available prior to complation of causa of daath? 24a. Was an autopsy performed? Completed 2 1 No 1 Tas 1 ☐ Yas 2 No certificate Division of Vital 25. Was casa rafarred to medical axaminar? Be 28. Placa of Daath (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Inpatient 2 ER/Outpatient 3 DOA this funerel 28a. Data of Injury (Month, Day Year) Certification: 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred of or Attending F effer death. After Natural 2 Accidant 5 Panding invastigation 1 Yas 2 No 6 Could not be determined 3 Suicida Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) in by 4 Homicide To the Hospital of within 24 hours of To the Funeral D 12 Certifying Phyeician: To tha best of my knowladge, daath occurred at the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Exeminar: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, dete and place, and dua to the causa(s) and menner steted. 29a. Certifier Medical (Check only one)

State

Registrar

31. Data filed (Month, Day, Year) SEP 1 7 1998

ANUJ K. MAHINDRA

funahindra, M.D.

30. Nama and addrass of person who complated causa of death (Item 23e) (Type, Print)

29b. Signatura and titla of certifiar

GOOD SAMARITAN 32. Registrar's Signatura

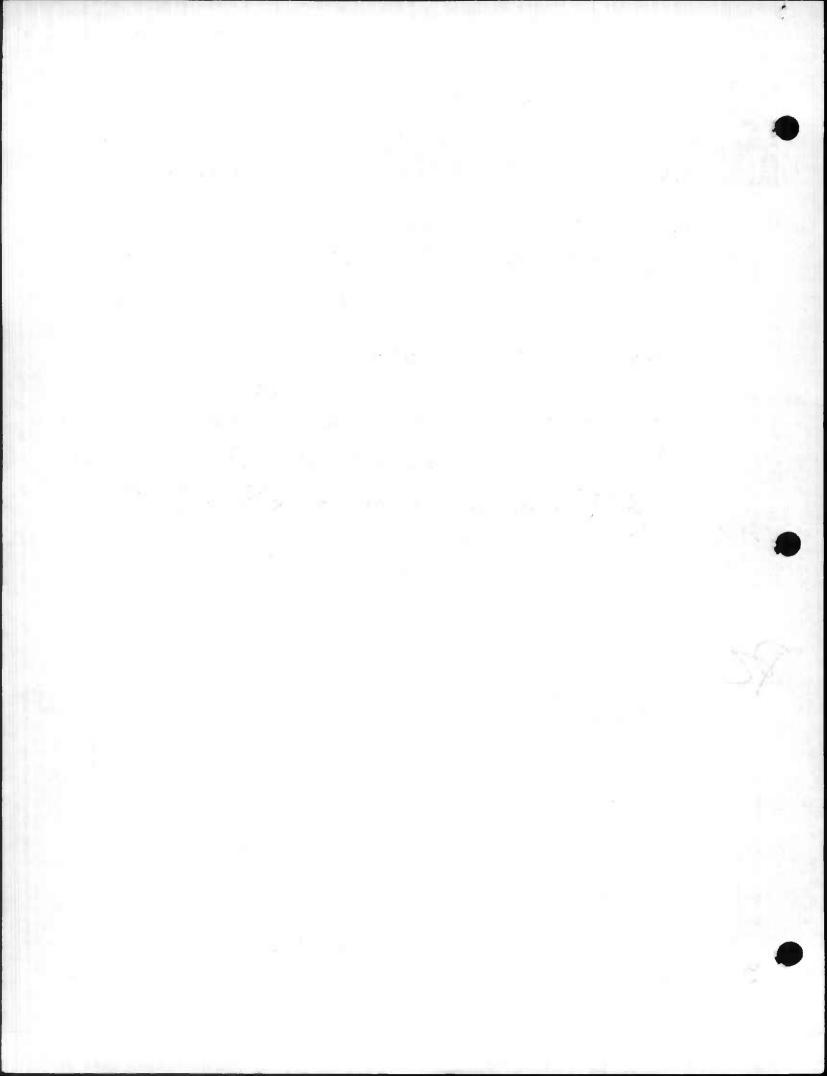
29c. Licansa number

RES 000

29d. Data signed (Month, Day, Year)

SEP 12 1998

HOSPITAL, BALTIMORE, MD.



#### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day Month Yeer I Sadore Ziskind 2316 September 12 1998 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street end number) Baltimere Mortland Ba H Under 1 Year H Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. MAY 22,1920 Baltimore City Itospital of Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign 1₩ M 2□ F MARYLAND 212-18-8453 78 Usual Residence of Decedent 10d. Inside City Limits 10a State 10h. County 10c. City, Town or Location 1X Yes 2 □ No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of Whet Country? 21215 3107 BANCROFT RD., APT. B USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ₩ Yes 2 □ No tf Yes, Give Yeer or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Merried 2 ☑ Married 1 ☐ Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) SOCIAL SECURITY CLERK 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ZISKIND BESSIE COHEN SAMUEL 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 3107 BANCROFT ROAD, APT. B BALTIMORE, MD 21215 MRS. EDITH ZISKIND (WIFE) 20b. Place of Disposition (Neme of cemetery, crematory or other place) ANSHE SFARD 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) OHR KNESSETH ISRAEL 9-15-1998 ROSEDALE, MD 22. Name end Address of Fecility 21. Signature of Buneral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting In death) Cohours Myocardia Artery oronary Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contributs to the cause of death? Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 Yes 25. Wes case referred to medical examiner? 28. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show a notified at

r than "natural", or items 23s or the Wedical Examiner must be a

permit. Pages 1 and 2 should be filed within 72 hours efter deeth 1 Depertment of Heelth and Mentel Hyglene. Important: If flem 27 is marked other than "natural", or Nems 234 any Injury or other traumatic event, the Medical Examiner must

altimore, Maryland 21215-0020

Directo

Funeral

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Completed

the Marylend

Examiner ician end buriel-transit Physician/Medical by Completed Be

certificate has b lirector, page 2 s Attending Physician; funeral s efter dec.

Division of Vital Records, P.O. Box 68760

6 Hospital 24 hours

Certification: To

edical

31. Dete filed (Month, Dey, Year) SEP 1 5 1998 Registrar

29b. Signature end title of certifier

27. Manner of Deat 1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

5 Pending

Investigation 6 Could not be determined

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

Cartifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end manner stated.

29d. Date signed (Month, Day, Year)

281. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

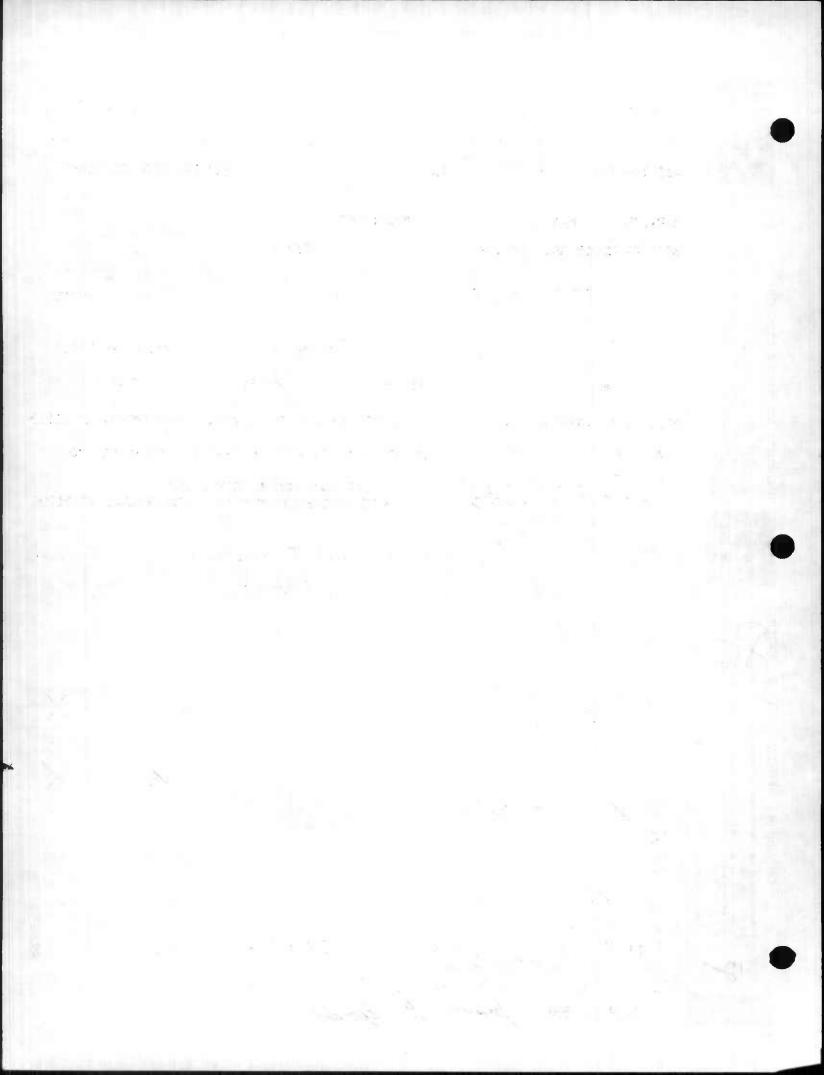
30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

West Beluglere Avenue Baltimore Maryland 21215 Narcus Mckenzie MD 2401

32 Registrar's Signature

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



	K.S HN ROBER	T	Pleas ANDERSON tems: 23 part I,27,2	Sta	te of M	arylan		artmen	t of F	lealth a	and N	-	ygiene 9		8583
	Physicia:	n	Decedent's Name (First, Middle,  JOHN ROBI	Last)								2. Date of D Month SEPT	eath Oay	Year 98	3. Time of Death  10:05 AM
	/Medica Examine		4a Facility Name (If not institution, 742 NORTH GORS							4b. City, To		ocation of Dea	th 4c. County		
	Funeral Director		220-36-9868	6. Sax		ga (In yrs. 58	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Data of B (Month, D JUL	irth Pay, Year) 19,1940	9. Birthp Cour MAR	otace (State or Foraign otry) YLAND
1	faryland abov		Usual Residence of Decadent  10a. Stata 10b. County  MARYLAND CA	ARROLL		10c. Cit	y, Town or Lo	ocation	-	HAMPST	PFAD			1	10d. Inside City Limits
	28e-	Director	10e. Street and Number	ичесть				10f. Zig		. LL L D			10g. Citizen of	What Cou	
	th with	2	3535 HOFFMAN MI	LL RO	AD					210	74		Ţ	JSA	
020	urs after death with the Manylar al', or Herns 23a or 28a-f show Examiner must be notified as	by runeral	11. Marital Status  1 □ Never Married 2 ▼ Marrie  3 □ Widowed 4 □ Divorced	Am d 1 E	is Dacedant ned Forces? Yes 2     es, Give ar or Dates:		58-	Was Dece If Yes, spe			gin? (Sp	ecify Yes or N Rican, etc.)	I4. Rad Bla Specif	ce - Amaric ck, Whita, y: W	
21215-0020	n 72 ho	Completed	15. Decedent's (Specify only highast Elementary/Secondary (0-12)	s Education grade comp			16a. Deced (Give lifa.	kind of wo DO NOT u	ork dona se retire	during mos d)			16b. Kind of B		
Maryland 2	Se se	lo pe co	17. Father's Name (First, Middle, L		2		DEPU	TA DI	REC.		er's Nam	e (First, Middl	TELI le, Maidan Sumar JLLIVAN		E SERVICE
	4430		19a. Informant's Name/Relationsh DORIS ANDERSON,		int)			_	100				ber, City or Town		
Baltimore,	The Head		20a. Method of Disposition  1 → Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp.		I from State	C	lace of Dispo emetery, crer	matory or	other pla		1	Date	20c. Location HAMPS'		
Baltir	permit. Page Department of Important: if any injury or once.		21. Signature of Furreral Servica L	•••	183	lea	22	2. Name ar	nd Addre	ess of Facili	ty	ELINE E	FUNERAL I	HOME	Winds III
0.00	Physician /Medical Examiner		23a. Part1. Entar tha disaasa, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	complication only one cause	s that ceusac se on each li	LE INJ				ng, such as	cardiac	or respiratory	arrest,		Approximate Interval Betwaan Onsat and Death
x 68760,	e 5 -	rnysiciarymedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last	c			r as a consec r as a conseq		:						
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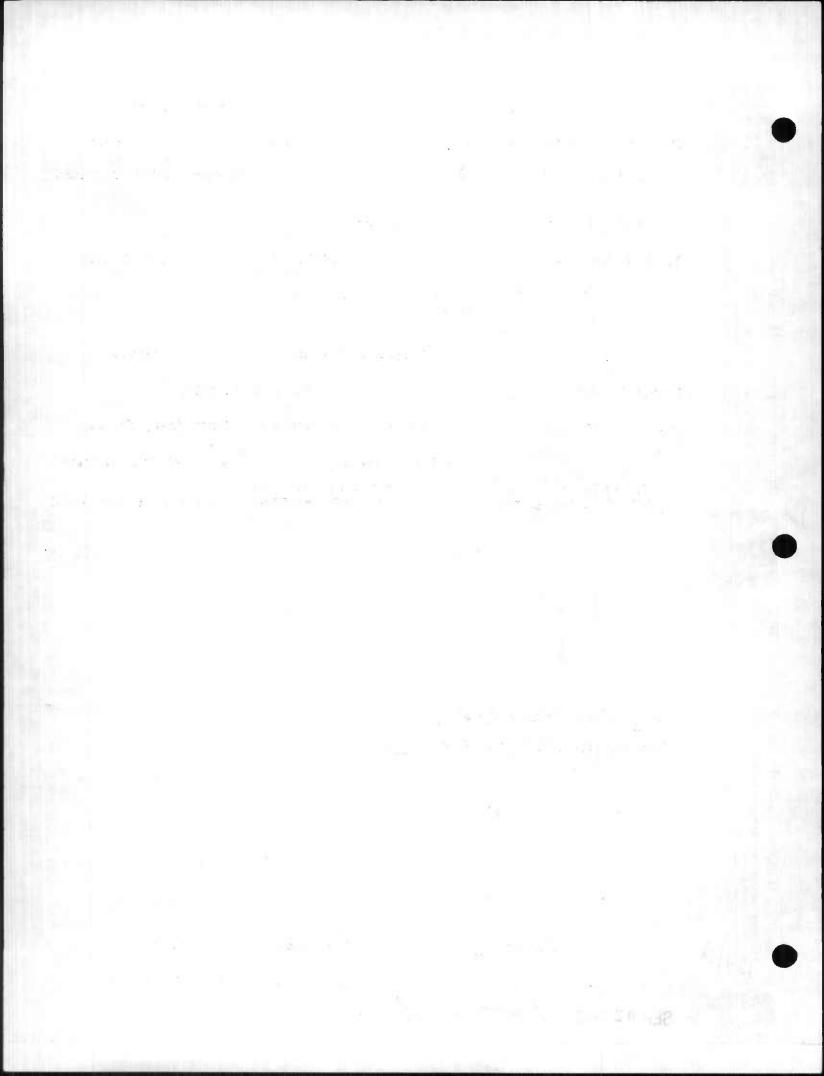
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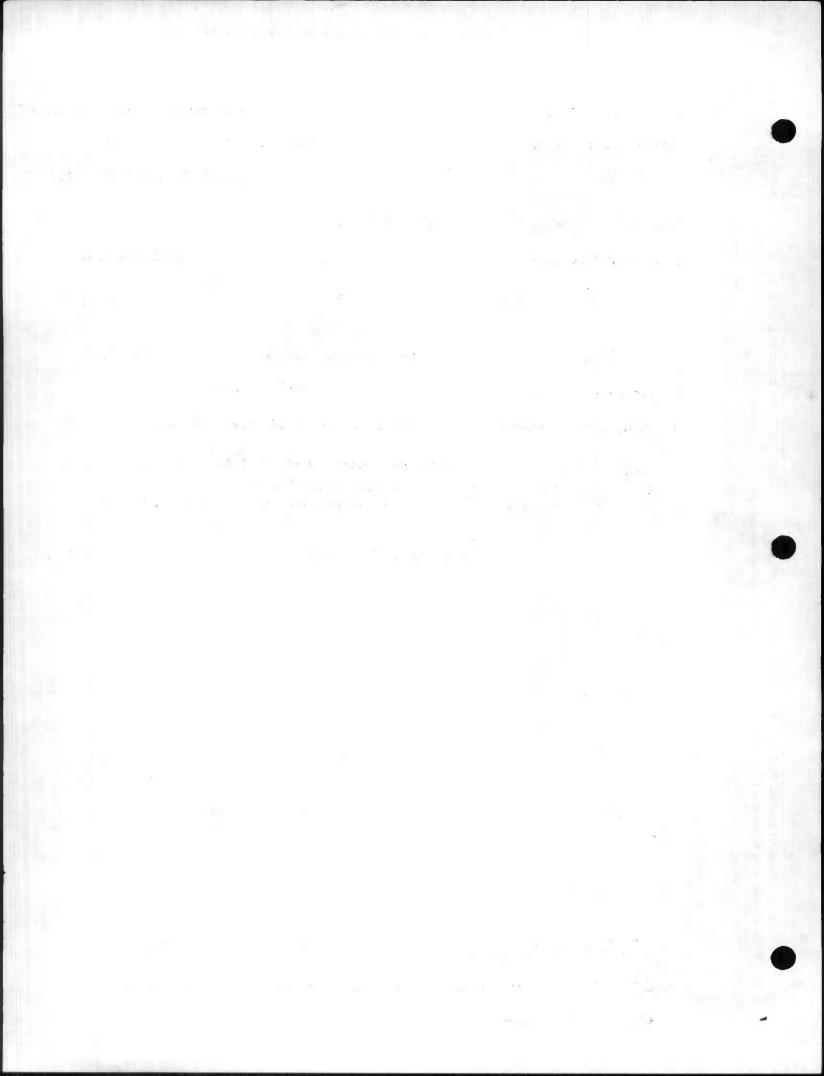
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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: if item 27 is merked other than "natural", any injury or other traumatic avant, its Medical Example. To Be Completed by	Lu	ther B.	Akers							Belle Li			
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/Medical	Patsy Ann Brow						ber 3, 1		11:05 AM
Examiner	4a Facility Name (If not institution, gi	ve street end number)			4b. City, Town, or L	ocation of Death	4c. County	of Death	
	1400 Belvidere Ro	oad			Port Dep			ecil	
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vith the Maryler or 28s-f show be restricted at Olrector	Maryland Cec	il	Port	Deposit					1 105 2 1010
or 22	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Count	ry?
23a al E	1400 Belvidere R	oad		2	1904		United	Stat	es
f Health and Mentel Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exertiner must be restitied at To Be Completed by Funeral Director	11. Marital Status	12. Was Decedent E	ver in U,S. 13	. Was Decedent of	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No	- 14. Rac	- America	
5 E	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☒ N				rican, etc.)		k, White, e	(C.
natural', o adical Exa- leted by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify	Whi	te
Completed	15. Decedent's E	ducation	16a. Dec	cedent's Usual Occu	upation		16b. Kind of Bu	siness/Indi	ustry
ple ple	(Specify only highest gi	ede completed) College (1-4or 5-	(Gite	ve kind of work done . DO NOT use retir	e during most of work	ing			
e mo	12	College (1-40) 5		issions C	oordinato		Nursin	g Hom	ie
To Be Comp	17. Father's Name (First, Middle, Las	1)			18. Mother's Nam	e (First, Middle	, Maiden Sumam	Θ)	
0 0 0	Robert Russ				Billy An	thur			
-	19a, Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Address (Stree	et end Number or Rui		er. City or Town.	Stete, Zip	Code)
tra.									001
any injury or other tr pnce.	Ralph E. Brown / 20a. Mathod of Disposition	Spouse		position (Name of	re Road, l	Date De	20c. Location		.904 vn. State
0 0	1 ₺ Burial 2 □ Cremation 3	Removal from State	cemetery, co	remetory or other pi	Se Se	ept. 7	Eggi Egginori	on, o	
i	4 Donation 5 Other (Spec	(ty)	West No	ttingham		1998	Colora,	Mary	land
DUCE	21. Signature of Funeral Service Libe	nsea)	7	22. Name and Add	ress of Facility neral Home	2			
a	Wel. 14	in X	3		Main Str		rth Fact	MD	21901
	23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused	tha death. Do not e	enter the mode of dy	ring, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
ian	shock, or neart failure. List only	one cause on each iin	е.					1	Onset and Death
al	Immediate Cause (Final		ancreati	- Canco	0./				7.3. 10
er	disease or condition resulting in death)		Due to (or as a cons		4	_		1	c yyen >
<u> </u>			Due to to as a cons	iequerice ory.				1	
Examiner	Comments the New York and Alberta	b	Due to (or as a cons	equence of):					
EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	The state of	Dire to (or as a corre	oquorios orj.					
	Cause (Disease or Injury that Initiated events	C	Due to (or as a cons	oguence of):				-	
is the buriel-transit edical Examir	resulting In death) Last		Due to (or as a cons	equence oi).					
of for use es		d							
for t									
/ Physician/M	Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause g	given In Part I.				tha cause of death?
돈						1 🗆	Yee 20 No	3 Prob	ably 4 Unknow
by								246 141-	ro autopou fin die -
Completed	20.00					24a. Was	an autopsy ormed?	ava	re autopsy findings illable prior to appletion of cause
ple								of d	leath?
NO.	1 to 14 to 14 to 15 to 1					10	Yes 20No	1	Yes 2□ No
Be	25. Was case referred to medical				26. Place of Dea	th (Check only	one)		
To Be Com	examiner?	Hospital:	nt 2 ER/Outpat	ient 3 DOA	her: 4 Nursing H	ome 5 Res	ldenca 6 □Oth	er (Specify	)
i	27. Manner of Death	28a. Date of Injur	y 28b. Time		ury at	28d. Describe	how Injury occur	red	
tio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day	Year) Injury		☐ Yes 2 ☐ No				
fice	3 Sulcide 6 Could not	28e. Place of Inju	ny - At home, farm,	street, factory, office	9	28f. Location (	Street and Numb	er or Rura	Route Number,
Certification:	4 Homicide	building, etc	. (Specify)	0.0		City or To	wn, Stete)		
0	29a. Certifier 1 Certifying P	hyelcfan: To the best o	f my knowledge de	ath occurred at the	time date and place	and due to the	cause(s) and mu	nner as st	ated
pletely fill edical		miner: On the basis of and manner sta	examination and/or						
completely filled in by the funer  Medical Certification:	29b. Signature and title of certifier	and mariner sta	iou.	29c Lice	nse number		29d. Date signe	d (Month, L	Dev. Year)
	200. Organical and this of certified	126 0					913	198	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Jan H W	major the M		9	44373		1/3	110	
	30. Name and address of person who	V							
154	Joseph K. Weidne	r, Jr., M.	D., 101 C	olonial W	Way, Risin	g Sun,	MD 2191	.1	
State	31. Date tiled (Month, Day, Year)	32 Registra	r's Signature						
Registrar	SED 0 4 1998	And Dear	, 14	dan de					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 2. Data of Death 1. Decedant's Nama (First, Middla, Last) Day Month Yaar 1340 **Physician** Mary I. Bauer 30,1998 August /Medical 4b. City, Town, or Location of Deeth 4a Facility Nama (If not institution, give street end number) 4c. County of Death Examiner Elkton Cecil

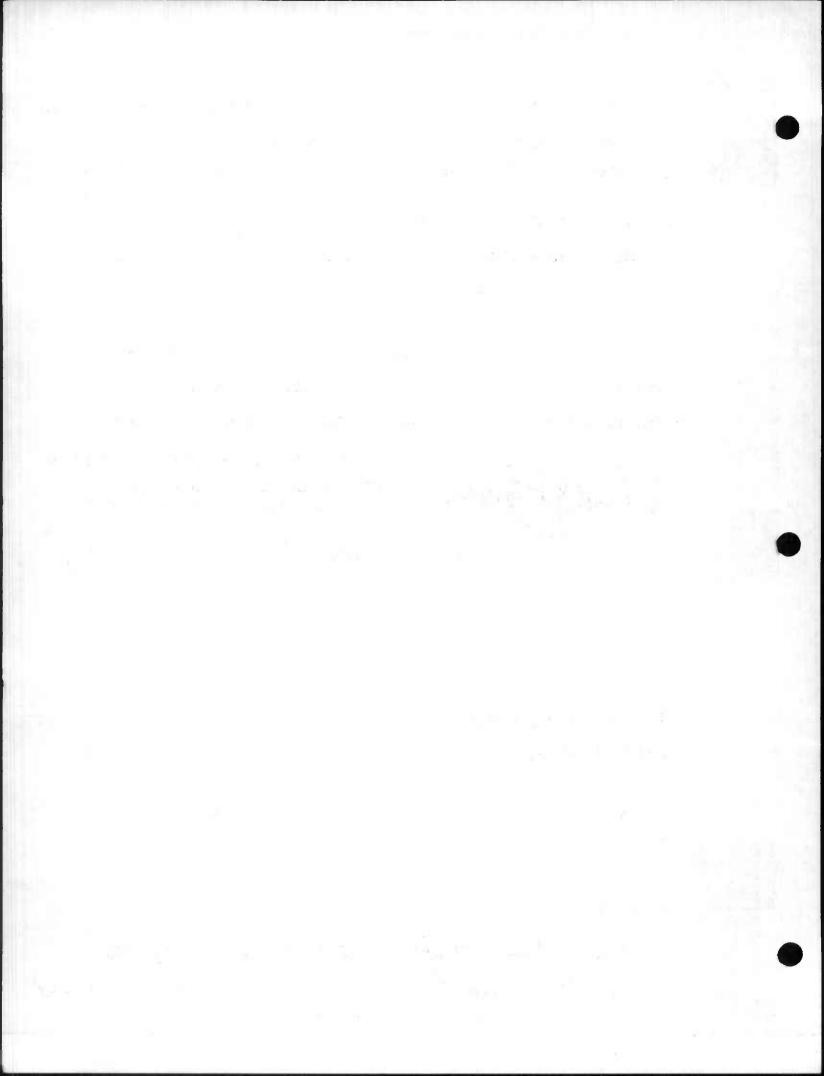
If Under 24 Hrs. 8. Data of Birth
Hours Min (Month, Day Year)
January 21, 1906 Indiana Laurelwood Care Center If Undar 1 Yaer 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1 M 3 F Months Days 92 Yrs. Director 316-22-1743 Usual Residence of Dacadent 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at with the Meryle 1 ☐ Yas 21 No Director Md. Ceci1 Elkton 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 149 Gina Court 21921 USA Funeral deeth 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - American Indien. Black, Whita, atc. 1 ☐ Never Married 2 ☐ Merrled Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White à 3 ₩ Widowed 4 Divorced Completed 16a. Decedant's Usual Occupetion 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) (Giva kind of work dona during most of working lifa. DO NOT usa retired) d 2 should be filed within 72 th and Mental Hygiene. Elementary/Secondary (0-12) Collaga (1-4or 5+) Homemaker 12 At Home treumetic event. 18. Mothar's Neme (First, Middle, Maiden Surnama) 17. Fethar's Nama (First, Middla, Last) Be William Trovinger 01 Goldie Moffett 19e. Informant's Nama/Raletionship (Typa, Print) 19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) Pages 1 end 2 sinent of Health an ant: If item 27 ie rury or other treur Paul Bauer, Son 149 Gina Court Elkton, Md. 21921 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☑ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Spacify) 9/1/98 West Chester, Pa. permit. Page Department of Important: If any injury or page. R. A. Ferris & Co 22. Nama and Addrass of Facility 21. Signatura of Funaçal Sarviça Licensed 259 E. Main St., Gee Funeral Home Elkton, Md. w 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not antar tha mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intarvel Between Onsat and Death Physician /Medical Immediata Ceusa (Finel disaasa or condition rasulting In daath) Dua to (or as a consaquanca of): 6 MONTHS Examiner Examiner physician end s the buriel-trans Sequentially list conditions, if any, laading to immadiata ceuse. Enter Underlying Causa (Disaase or Injury that initiated avants rasulting in daath) Last Dua to (or es a consaguence of): certificate be exec P.O. Box 68760 Physician/Medical Dua to (or as a consequence of) 88 use 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records. by 24b. Ware eutopsy findings evailable prior to 24a. Was an eutopsy Completed completion of causa of death? hes page 2 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) To 1 Yas 2 No this 28a. Data of Injury (Month, Day Yaar) funeral 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of Certification: After 5 Pending investigation 1-Neturel or Attending after death. Director: Aft 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarmined 3 ☐ Suicida Location (Straat and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, streat, fectory, office building, etc. (Specify) 4 | Homicide 24 hours Hospital 12 Certifying Phyeicien: To the best of my knowledge, death occurred at the time, data and place, and due to the ceuse(s) end mennar as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. edical 29a. Certifier (Check only one) To the I within 2 29d. Data signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. Licansa number Monte My leons, MD D-44783 August 31,1998 30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print) 3 ELKTON, MO 21921 III West High STREET, MAKOUS MONTE MD 31. Data filed (Month, Day, Year) 32. Registrar's Signatura Registrar SEP 0 2 1998

out will test MATERIAL PROPERTY. Total part tempore in ENTERFOR STOLENSON STOLENSON STOLENSON

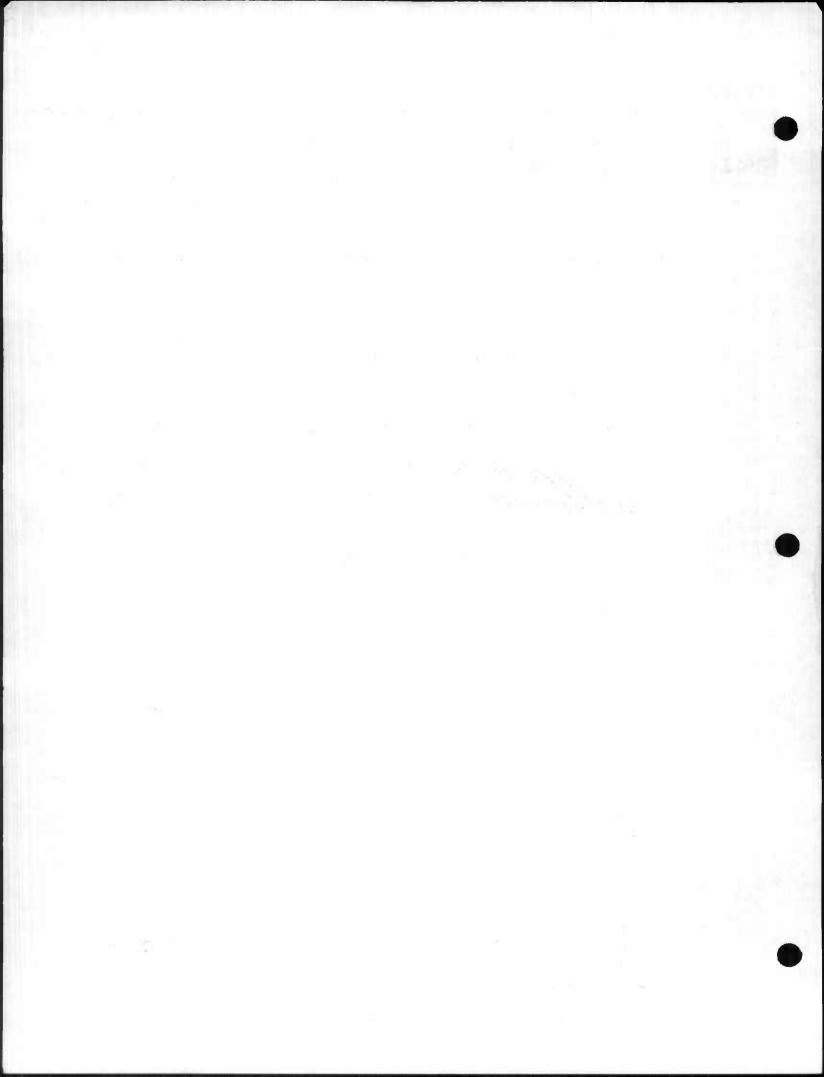
	_				Cei	tificate of	Death		Reg. No.	90	. 85	87
ciar	n	1. Decedant's Nama (First, Middla, La						2. Data of Month	Day	Year		ma of Death
lica	ıl .	ALMA ELIZABETH E  4a. Facility Nama (If not institution, giv		ue)			Ah City Toy	SEPTE wn, or Location of D	MBER 4	, 1998 County of Deat		45PM
ine	r	6420 SUICIDE BRID		er)			HURLOC			ORCHES'		
Ī	п	5. Social Security Number 6. S		Age (In yrs.	last birthday)	if Undar 1 Yaer	if Undar 2		_			tata or Foraign
d		216-46-6930	□M 2ŪXF	88	Yrs.	Months Deys	Hours	Min. APRIL	Birth Day, Year) 7,191	0 MAR	YLAND	)
	-	Usual Rasidance of Dacedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation					10d Inci	de City Limits
1	5	MARYLAND DORCHES	тгр		LOCK	oution,						Yas 2 No
1	Director	10e. Street and Number	IDK	1101	HOOK	10f. Zip Coda			10g. Citiza	an of What Co	ountry?	
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-	Funeral	11. Marital Status	12. Was Dacadar Armed Forcas	nt Evar In U	,S. 13. V	Vas Dacedenf of	Hispenic Orig	in? (Specify Yas or Puarto Rican, atc.)	No- 14	Race - Ame		an,
Per	6	1 Nevar Married 2 Merried 3 Widowad 4 Divorced	1 ☐ Yes 2 ☐ If Yas, Giva Yaar or Dates	No		☐ Yes 2 No		, , , , , , , , , , , , , , , , , , , ,		inecity:	white	
-	Completed	15. Decedent's Ed (Specify only highast gra			16a. Deced	ant's Usual Occu kind of work done	pation during most	of working	16b. Kind	d of Businass/	Industry	
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		8 17. Fethar's Nama (First, Middla, Last)			HO	MEMAKER	18 Motha	r's Name (First, Mic		HOME		
a	a a	JOHN ANTHONY						ARET WIL		umamay		
F	0	19a. Informant's Name/Ralationship (	Type, Print)		19b. Mailin	g Addrass (Straa		r or Rural Routa Nu		Town, Stata, 2	Zip Code)	
		EDWARD C. BOZEL/	SON		6420	SUICIDE	BRIDG	GE ROAD, 1	HURLOCK	, MD 2	1643	
		20a. Mathod of Disposition 1 ☑ Buriai 2 ☐ Cremation 3 ☐	Removal from Stat		Place of Dispo ematary, cran	sition (Nama of natory or other pla	ace)	Data	20c. Loc	ation - City or	Town, Sta	ita
		4 Donation 5 Other (Spacifi			W CATHE	EDRAL CE	METERY	9/8/98	BALT	IMORE,	MARY	LAND
		21. Signature of Filmeral Service Vicen	25/	1	7.F.	Nama and Addr	ass of Facility	OME, 106	MATN S	TREET.		
		Longuelt	- gel	er	P.	O. BOX	207, E	EAST NEW I	ARKET,			
ľ	1	23a Part Enter the disease, or come shack, or heart failure. List only	plication, that ceus	ed the daat line.	h. Do not ente	er the mode of dy	Ing, such es o	cardiac or raspirato	y arrast,		Approx	kimata Il Between end Death
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ı	1	diseasa or condition rasulting in deeth)	a		or as a conseq	ilure					Da	45
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		Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Ceusa (Disaasa or Injury	С.									
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lois	200	Part II. Other algnificant conditions of	ontributing to death	but not res	ulting In the ur	ndarlying causa g	ivan in Part I	23b. I	Did tobacco u	se contribute	to the ca	use of death
Shve		N-111 R1				idanying oddaa g	ivan iii r uit i.		☐ Yas 22			4 Unknow
3	2	HOUTE 14	nal to	all	ire							
Completed	3	Hypothur	Dick						Vas an autops erformed?	1	Wara auto avallabla p completion	opsy findings orlor to
jou			UI (M								of daath?	
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S C		25. Was cesa rafarred to medicel examinar?  1 ☐ Yas 2 ☑ No	Hospitai: 1 ☐ Inpa	tions O	ER/Outpatian	2 DOA 01	har	of Death (Check or		[]Other (C	a/4 s)	
T.		27. Manner of Deeth	28a. Data of In	jury	28b. Tima of	t 3□ DOA 28c. inju		rsing Homa 5 📑	be how injury		спу)	
atio		1 ☑Natural 5 ☐ Panding 2 ☐ Accident invastigation	(Month, E	ay Year)	injury		ork? ]Yas 2□N	No				
Cartification.		3 ☐ Suicide 6 ☐ Could not be datarminad	289. Place of I	njury - At he atc. (Specif		aet, factory, office		28f. Location City or	on (Straat and Town, Stata)	Number or R	u <i>ral R</i> outa	Number,
adical C		29a. Cartifiar (Check only one)  12 Certifying Ph. 2 Madical Exam	ysician: To the bes ninar: On the basis and manner:	of examine	wledge, daath tion and/or Inv	occurrad at the trastigation, in my	ima, data and opinion, daati	d place, and dua to h occurrad at tha tir	tha ceusa(s) a ne, data and p	nd manner as place, and dua	s steted. a to tha ca	usa(s)
2		29b. Signature end title of certifiar	and mainer:	stated.		29c. Lican	sa number		29d. Date	signed (Mont	th, Day, Xe	ear)
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				1 11/1	1/1		000	1-1X Z		17111	7	
		30. Name and eddrass of person who	completed.cause of	death (Item	tad crune	Print)		9			9	
		30. Name and eddrass of person who	completed cause of	death (Item	and grype.	Print)	E	a stim	· n	70	21	601

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State of Maryland / Department of Health and Mental Hygiene 📵 🔎

						(	Certi	ificate of	Death		Re	g. No.	6	0000
		1. Decedant's Nama (First, M.	ddla, L	ast)	WIL.	Y-195	1			2. Data Mor	of Death	Dey	Yaar	3. Tima of Death
Physicia /Medic		BUTH		A.	(	HAP	a			Ser	101		CAK	1012 Au
Examin		4a. Facility Nama (If not institu	tion, gi	va street and numb					4b. City, To	wn, or Location of	f Death	4c. County	of Death	
		Carroll Luth	erai	n Village					Vestmi	nster		Carro	11	
Funeral		5. Social Sacurity Number	6.	Sax 7.	. Aga (In yrs	. last birth		if Undar 1 Yaar	if Undar	24 Hrs. 8. Date	of Birth			placa (Stata or Fora
Director		213-28-5545		1 M 2 C★F		87 Y	rs.	Months Days	Hours		15,			yland
D		Usual Rasidanca of Decedant												, 10110
death with the Marylend ims 23s or 28s-f show it must be notified at		10a. Stata 10b. Cou	nty		10c. C	ity, Town	or Loca	tion					1	0d. Insida City Limi
Ma-f.s	tor	Maryland Carr	011		M	ary1	and							1 □ Yas 2X N
r 28	řě	10e. Street and Number						10f. Zip Coda			10	g. Citizan of	What Cour	ntry?
3a o	0	205 St. Mark	wav	Apt 125.				21158			71	nited	Chah	
s 1 and 2 should be filed within 72 hours efter death with the Maryler of Health and Mental bygiene. If health and Mental bygiene "retural", or items 23a or 28a-f show then 21 is marked other than "retural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Directo	11. Marital Status		12. Was Deced	ant Evar in	U,S.	13. Wa		Hispanic Or	igin? (Specify Ya: n, Puarto Rican, a				ean indian,
ter ite	Fur	1 Navar Marriad 2 □ N	farried	Armad Forc			if Y	as, specify Cul	oan, Maxica	n, Puarto Rican, a	itc.)	Bla	ck, Whita,	atc.
If, o	by	3 ₩idowed 4 Divor		If Yas, Giva Yaar or Date			1	Yas 2 No	Specify:			Specify	v: Whi	ite
72 hours efter natural', or ite dicel Examine		15. Dece	lant's F			16a E	Deceder	nt's Usuai Occu	pation		1	6b. Kind of B	usinass/Inc	dustry
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and Men	2	Chester Hobb								ecca Hoc				
ia n		19a. informant's Name/Raiati		(Type, Print)						er or Rural Routa				Coda)
M Health Item 27 other tr		Michael Tayl	or	Grands		140	)9 P	lacid I	r. Sy	kesville				
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permit. Pages Department of Important: If It any injury or o		21. Signature of Funarai Serv	وكاماوه	ply //			22. 1	lama and Addr		ty				
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the at	Sici	Part il. Othar aignificant cond	itions	contributing to daat	th but not ra	sulting in t	tha unde	erlying cause g	iven in Pert	1. 23	b. Did tol	oacco use co	ntribute to	o the cause of deat
	Physician/Medical	AIL	~	24							1 □ Ye	2 □ No	3 Pro	bably 4 Unkno
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certificate rector, pag	Be	25. Was casa referred to med axaminar?	ical	Hospital:						e of Death (Checi	k only one	1)		
2 B	2	1 ☐ Yes 2 ☐ No		1 L inc		ER/Outp		3LI DOA		ursing Home 5			-	y)
After this certific funeral director,	Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Par	dina	28a. Data of (Month,	Injury Dey Year)	28b. Tir Inj	me of ury	28c. Inje	iry at ork?	28d. Da	scribe ho	w injury occur	red	
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after death. Director: After in by the fune	Ĭ	3 ☐ Suicida 6 ☐ Cou	ild not b arminec	286. Place of	f Injury - At i	homa, farn	n, stree	t, factory, office			ation (Str		oer or Rura	al Routa Number,
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within 24 hours after deall To the Funeral Director: completely illed in by the		29a Certifier 1 Certif	ying Pl	hysician: To the be	est of my kn	owladga,	daath o	ccurred at tha t	ima, dete an	nd place, and due	to the ca	use(s) and me	ennar as s	tated.
within 24 hours after dear To the Funeral Director. completely filled in by the	edical	(Check only 2 Madic	al Exa	minar: On the basi	is of examin r stated.	ation and/	or invas	stigation, in my	opinion, dea	th occurred et the	e time, da	te end place,	end due to	) Iha causa(s)
of the	Ň	29b Signature and title of cen	_						sa number			d. Data signa		
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	1	30. Name and addrass of pers			of death (ita	m 23a) (T	ype, Pri	int)	21158					\ \
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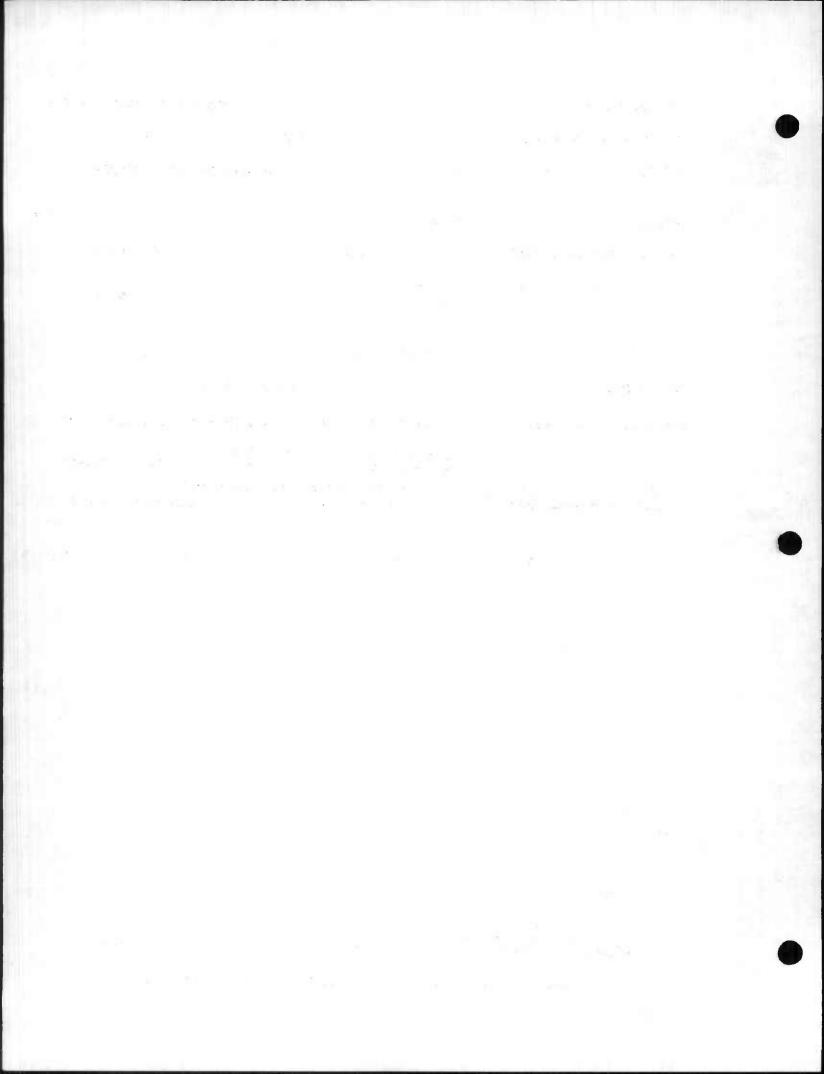


## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

Physic	_	Decedent's Nama (First, Middla, L.)	( act)	Ce	ertificate of	Death	2. Deta of Death	g. No.	3. Tima of Death
FILIPAIC	ian						Month	Day Yaa	r.
/Medi		Robert E. Doughe						er 2, 199	
Exami	ner	4a. Fecility Nama (If not institution, g				4b. City, Town, or L		4c. County of De	eth
		Calvert Manor He				Rising		Cecil	
Funeral		5. Social Security Number 6.	Sax 7. Ag	a (In yrs. last birthda)	Months Days	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day,	Year) 9. B	irthpiace (State or Foreigr Country)
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p z		Usuel Rasidance of Decedant  10a. Stata 10b. County		10c. City, Town or	ocation				10d Incide Oh, Limite
show	-	Tou. Oldiny		Too. Only, Town of	Location				10d. Insida City Limits 1 ☐ Yas 2 ☒ No
No Maria	Director	Maryland Cecil		Rising S					
F 22	- L	10e. Streat and Number			10f. Zlp Coda		10	g. Citizen of What (	Country?
23a		1881 Telegraph F	Road		21913	1		United S	tates
ep L	Funeral	11. Marital Status	12. Wes Decedent Armed Forcas?	Ever in U,S. 13	. Was Decedant of I	Hispanic Orlgin? (Spen, Mexican, Puarto	ecify Yes or No- Rican, atc.)	14. Race - An Black, Wh	narican Indian,
d within 72 hours after death with the Maryland Jiene. "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at	þ	1 ☐ Nevar Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced		No WWII	1 ☐ Yas 2 ☑ No	Specify:	Thous, aro.,	Specify: V	
2 ho	Completed	15. Decedant's I		16a. Dec	edant's Usuel Occup	pation	1	6b. Kind of Busines	ss/Industry
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filed within Hygiene. other than	Eo	8	Comaga (1-401)		efitter			Chemical	
호 첫 등 부	Be C	17. Fether's Nema (First, Middle, Las	st)			18. Mother's Nam	e (First, Middle, M	alden Sumame)	
d 2 should be fi th and Mental H 7 is marked out traumatic ever	To B	Samuel J. Doughe	erty			Abigai:	Steiger		
d 2 should th and Mer 7 is marke traumatic	-	19a. Informant's Name/Raiationship	(Type, Print)	19b. Ma	ling Addrass (Streat	and Number or Ru	al Route Number.	City or Town, Stata	Zin Code)
				Carrier.					
of Haelth a ltem 27 is other trac		Sam P. Dougherty 20a. Mathod of Disposition	y/ Son	20b. Place of Dis	position (Nema of			Oc. Location - City of	aware 19709
		1 Burial 2 □ Cramation 3		cemetary, cr	ematory or other pla	sept	ember 5,		or rown, oraco
tmer tent		4 □ Donation 5 □ Other (Spec			nts Cemete		1998 W:	ilmington	, Delaware
permit. Pages Department of Important: If II any Injury or once.		21. Signetura of Funarai Service Lice	ensea		22. Nama and Addre		arala D	7\	
Z O E # 9		Donal	2 His						aryland 219
		23a. Pert1. Entar tha disaasa, or con shock, or haart failure. List only	mpilcations that caused	the daeth. Do not a	ntar tha moda of dyl	ng, such as cardiac	or raspiratory arra	st,	Approximate
Physician		SHOCK, OF HARR RAILURG. LIST OFF	ly ona causa on aach iii	18.					Interval Between Onsat end Death
/Medical		Immediata Ceusa (Finel	$\sim$	1 1	Ma1. a	Lank			75000
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	ē			Dile to (or as a cons	equence of):				
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al-tra	ха	Sequentially list conditions, if any, laading to Immediata cause. Entar Undarlying Cause (Disaasa or Injury		Dua to (or as a cons	equence of):				1
ficata be executed physician and is the burial-transit		Cause (Disaasa or Injury	c						
icata phys	edical	that initiated evants resulting in daath) Last		Due to (or as a conse	equance of):				
Sec. 175. 45			d						
that the death certif ed by the attending detached for use as	lan								
the g	/slc	Part II. Other significant conditions	contributing to death b	ut not rasulting in tha	undarlying causa glo	van in Part I.	23b. Did tot	acco une contribu	ite to the cause of death
at the	Physician/M	To die of	+ 60.00	l'abolea	Malla		1 □ Ye	2 10 No 3□	Probably 4 Unknow
s 50	þ	DSOLIN CX	pendent a	MI SE MOTOR	TALLING Z				
v requires been sign should be	Completed	CHE Alex	tosis, C	000	204		24a. Was an		. Ware autopsy findings available prior to
\$ \$ ₹	ple	CITY TO BUS	40515 C	0/2	(20)				completion of cause of death?
	E						1 □ Ya	2 1 No	1 ☐ Yas 2 ☐ No
ha law e hes aga 2		25. Was casa rafarred to medical				00.01 (0.0			1 Tas 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
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t sag	Be C		1 Inpatie		ent 3LI DOA	4 Nursing Ho		nce 6 Other (Sp	pecify)
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rospita or Arendong Physician: 4 hours efter death. Funcial Director: After this certification filled in by the funeral director, it	edical Certification: To	27. Mannar of Death 1 Natural 2 Accidant 3 Sulcida 4 Homicida  29a. Certifier 1 Certifying P	(Month, Da) be d 28a. Place of Injuding, etc	ury - At homa, ferm, s (Specify) of my knowledga, dea axamination and/or i	M 1 □	ma, data and place,	City or Town,	Stata) use(s) and mannar	as stated.
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The reserve is constructed the profit of the region of the second of the A CONTRACTOR OF THE PROPERTY O

Acceleration of the control of the c	John D. Dotson  4e. Fecllity Name (If not institution, given 2960 Old Elk Neck 5. Sociel Security Number 6. S				Septemb	er 1, 199	3. Time of Dea	
eral	2960 Old Elk Neck 5. Social Security Number 6. S					LET T' TOO	8 7:58 a	
ctor	5. Sociel Security Number 6. S	Dana		4b. City, Town, or	Location of Deeth	4c. County of De	eth	
ctor		коаа		Elktor		Cecil		
	229-03-34/1	Sex 7. Age (In yrs 11 € M 2 F 80	( last birthday) If Under Months		8. Date of Birth (Month, Day, nuary 29,	<sup>Year)</sup> 1918 Vir	irthplece (Stete or For Country). ginia	
	Usuel Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Location				10d. Inside City Lii	
tor	Maryland Cecil	Elk	ton				1 Yes 20	
Director	10e. Street end Number		10f. Zip	Code	1	0g. Citizen of Whet (	Country?	
al D	2960 Old Elk Neck	Road	2192	1	τ	Inited Sta	tes	
by Funeral	11. Marital Status  1 Never Married 2\(\bigs_{\text{Married}}\) Married  3 \(\bigs_{\text{Widowed}}\) 4 \(\bigs_{\text{Divorced}}\)	If Yes Give	943- 945 13. Was Deceded If Yes, special 1 Yes 2	ent of Hispenic Orlgin? (S ify Cuban, Mexicen, Puerl No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - An Bleck, Wh Specify: W		
Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)	ducetion ade completed) College (1-4or 5+)	16a. Decedent's Usue (Give kind of work life. DO NOT use	Occupetion k done during most of wor e retired)	king	16b. Kind of Busines	s/Industry	
S	6		Coal Miner			Mining		
Be	17. Fether's Neme (First, Middle, Last)	)			ne (First, Middle, M	Maiden Sumeme)		
L <sub>o</sub>	George Dotson	T 0:4	1	-	Coleman			
	19a. Informent's Name/Relationship (			(Street end Number or Ru				
To Be Completed	Peggy H. Dotson/ 20a. Method of Disposition	20b.	Plece of Disposition (Nem	lk Neck Road		20c. Location - City of		
	1 StBurial 2 □ Cremetion 3 □	THemoval from Stete	cemetery, cremetory or of	her place) Septer	mber 4,			
	4 Donetion 5 Other (Specify 21. Signeture of Funerel Service Licer	М.	emorial Park	Address of Fecility	1998	Elkton, M	laryland	
once.		1.		ome for Fun	erals, P.	.A.		
	Janua X	Hucken	103 Wes	t Stockton	Street, El	Lkton, Mary		
	23e. Part1. Enter the disease, or com shock, or heert failure. List only	one ceuse on each line.	in. Do not enter the mode	or dying, such es cardiac	or respiretory erre	est,	Approximate Interval Betwee Onset and Deer	
ian cal	Immediate Ceuse (Final			2.0				
er	diseese or condition resulting in deeth)	e. LEFT PA		ITAL BR	AIN 7	UNUN	3 MO	
ē e		Due to (	or es e consequence of):					
Examiner	Sequentially list conditions	b. Due to (						
	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury		.,.					
edicai	Ceuse (Disease or injury thet Initieted events resulting in deeth) Lest	C. Due to (	or es e consequence of):					
	resulting in destrip Lest							
an		d	+=					
Physician/M	Pert II. Other significent conditions of	ontributing to death but not re-	sulting In the underlying ce	use given in Pert I.	23b. Did to	bacco use contribu	te to the cause of de	
P.					1 🗆 Y	00 2□No 3□	Probably 4 Unk	
by							,,	
Completed					24e. Was er		<ul> <li>Were eutopsy finding eveileble prior to completion of caus</li> </ul>	
ig m							of deeth?	
					1□ Ye	s 2 No	1 ☐ Yes 2 ☐ No	
Be	25. Was cese referred to medicel examiner?	Hospital:		0.11	th (Check only on			
12	1 Yes No	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatient 3 DO/ 28b. Time of 28		ome 5 Reside 28d. Describe ho	nce 8 Other (Sp	pecify)	
tion	Naturel 5 Pending investigation	(Month, Day Year)	Injury	3c. Injury et Work? 1 ☐ Yes 2 ☐ No	200. Describe no	w injury occurred		
8	3 Suicide 6 Could not be	0	ome, farm, street, factory,		28f. Location (St.	reet and Number or i	Rural Route Number,	
9	4 Homicide	building, efc. (Speci	fy)		City or Town	, Stete)		
entif	1	yelcien: To the best of my kno	owledge, deeth occurred e etlon end/or investigation,	t the time, date end place In my opinion, deeth occu	, and due to the ce rred et the time, de	euse(s) end menner o ete end plece, end do	es steted. ue to the ceuse(s)	
Medical Certification: 1	29a. Certifier (Check only one) Certifying Ph	end menner stated.						
Medical Certif	Check only 2 Medical Exam	end menner stated.	29c.	License number	29	9d. Dete signed (Moi	ryth, Day, Yeer)	
edicai	one) 2   Medical Exam	end menner stated.		The state of the s	29	9d. Dete signed (Mor	ryth, Day, Yeer)	
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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health a	nd Mental Hygiene	
Certificate of Death	Reg. No. 3 8 2.	8591
	2. Data of Deeth Month Day Yeer	3. Tima of De
ates	SEPTEMBER 2, 1998	1245

**Physician** /Medical Examiner

1. Decedent's Name (First, Middle, Last, Marvin Andrew Gates ath

**Funeral** 

Director

tha Maryland r 28a-f ahow permit. Pagas 1 and 2 should be filed within 72 hours after death with t Department of Haalth and Mental Hyglene. Important: If item 27 Is merked other than "natural", or items 23a or 3 any injury or other traumatic event, the Montal Examinat must be n

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

requires that the daath certificata be executed physician and tha burial-trans Division of Vital Records, P.O. Box 68760, 88 usa for signed by the a should cartificata has b or Attending Physician: director, this funaral Aftar 24 hours aftar daath. Funeral Director: A filled in by To the Hosp within 24 hor To the Fune completely fi

PM 4b. City. Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, giva street end number) **#1 IRVING PLACE** INDIAN HEAD CHARLES If Undar 1 Yaar | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Months Deys Hours Min. 1 M 2 □ F 43 Yrs. July 27, 1955 220-62-5360 Washington D.C. Usual Rasidence of Decedent 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Indian Head Maryland Charles 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 20640 U.S.A. #1 Irving Place Funeral 12. Wes Decedent Ever In U,S. Armad Forcee? 1 ☐ Yas 2 Ê No If Yas, Give Yeer or Dates: 14. Race - American Indien, Was Decedent of Hispanic Ortgin? (Specify Yes or No-If Yes, spacify Cuban, Mexicen, Puerto Rican, atc.) 11. Marital Status Bleck, White, etc. 1 ☐ Nevar Marriad 2 ☐ Married 1 ☐ Yes 2 ➡ No Specify: Specify þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grade completed) Elemantery/Secondary (0-12) College (1-4or 5+) Truck Driver Propane Company 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Catherine Irene Willett Marvin Edward Gates 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) (64) #9 Fairmont Place, Indian Head, Indian Head, Md. Sister Sharon McKimmie 20b. Plece of Disposition (Name of cemetery, cremetery or other pleaseptember 4, 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Funeral Services Alexandria, Virginia 22. Name and Address of Fecility
Williams Funeral Home, P.A. 21. Signetura of Funeral Service Lie M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 a of complication, that caused had deally. Do not anter the mode of dying, such as cerdiac or raspiratory errest, List only ona cause on each line. 23a. Pert1. Entar tha different shock, or haert fallum Approximata Intarval Between Onset end Death Immediete Ceuse (Finel disaasa or condition resulting in deeth) Due to (or es a consaquance of): Examine Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in daath) Last Due to (or es a consequance of): Physician/Medical Due to (or es e consequence of) 23b. Did tobacco usa contributs to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 ☐ Yss 2 ☐ No 3 Probably by 24b. Were eutopsy findings eveilable prior to completion of cause of daeth? 24e. Wes en eutopsy Completed pernomed RE 2 No 2 No Yes Be 25. Was case rafarred to medicel exeminer? 28. Piece of Deeth (Check only one) Other: 4 Nursing Home XX Residence 6 Other (Specify) Hospital: XX Yas 2 No 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Deta of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 27. Mannar of Death 28b. Time of 28c. Injury et Work? Certification: XX Natural
2 ☐ Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Spacify) 4 - Homlcida 1 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data end place, end due to tha causa(s) end menner as statad.

2 Medical Examiner: On the best of axamination and/or investigation, in my opinion, daath occurred at the time, data and place, end due to the cause(s) end manner stated. 29a. Cartifian Medical (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number SEPTEMBER 3, 1998 OCME

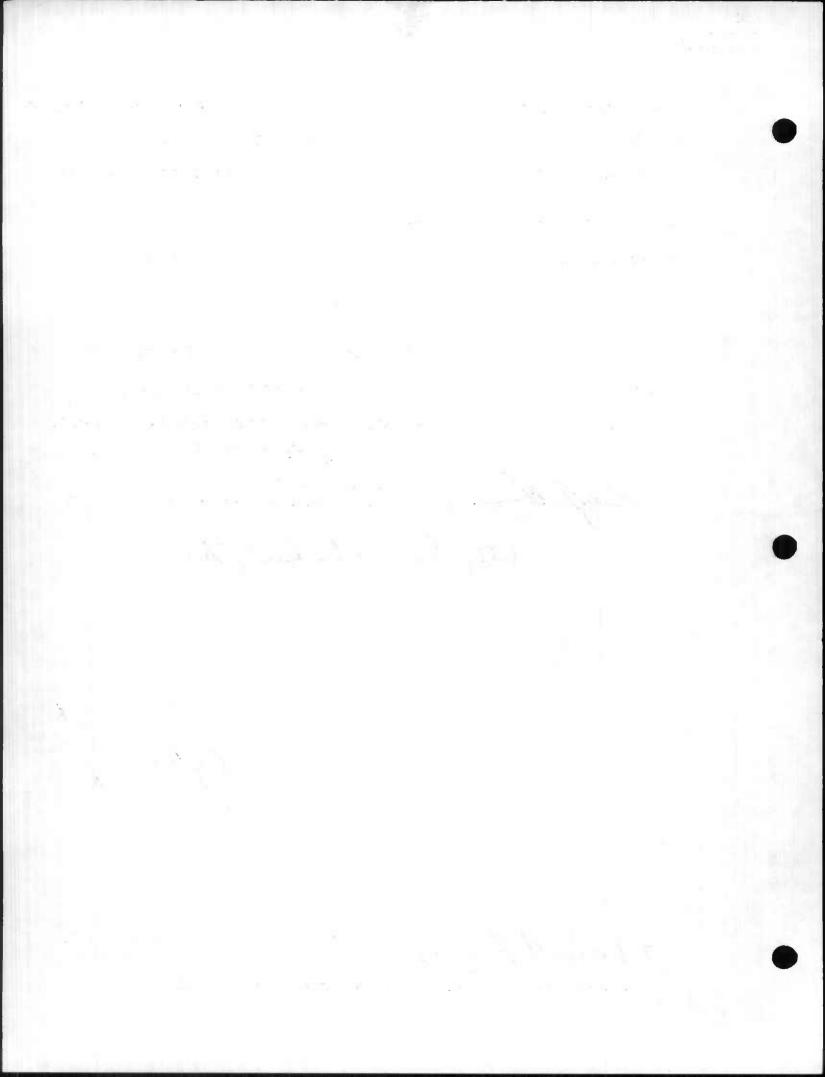
State Registrar

Theodore King M.D. 31. Data filad (Month, Day, Year) SEP 08 1998

32. Ragistrar's Signeture

30. Nama end eddrass of person who complated ceusa of drath (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September Day **Physiclan** 1650 Carroll M. Jones /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner E1kton Union Hospital Ceci1 5. Social Security Number 219-03-6715 # Under 1 Year # Under 24 Hrs. Months Days Hours Min. 8. Date of Birth May Year) 914 9. Birthplaca (State or May 31, 1914 Maryland 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** 15 M 2 F 84 Vre. Director Usuel Residence of Decedent the Manyland 10c. City, Town or Location Elkton 10d. Inside City Limits Maryland Cecil 7 ie marked other than "natural", or items 23a or 28a-f show treumstic event, ihe Modical Examiner must be notified all Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 Chesapeake ElderyApartments 21921 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours effer of Department of Healine and Menlat Hygiene. Important: if item 27 le marked other than "natural; or item any injury or other treumatic event, the Madical Examinat 1 Never Merried 2 Married 1 ☐ Yes 2√√No If Yes, Give Year or Dates: Specify: White 1 Yes ZENo Specify: þ 3E Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use refined)
Truck Driver 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Concrete 17. Father's Name (First, Middle, Last)
Charles Jones 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Simmons 19a, Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Eldreth #30 Alda Drive Elkton, Maryland 21921 20b. Place of Disposition (Name of 20e. Method of Disposition Date 20c. Location - City or Town, State E18ton Cemetery XXBuriai 2 Cremation 3 Removal from State 9-9-98 Elkton, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funerel Service Licensed 22. Name and Address of Facility Gee Fuweral Home 259 E. Main St. ElktonMd Air 23a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** immediate Cause (Final disease or condition resulting In death) /Medical Sepsie Syndrome
Due to (or as e consequence of): Examiner Examiner Uninary Tract
Due to (or a a consequenca of): sician end buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ettending physician for use as the burie Physician/Medical Due to (or es e consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 PNo 3 Probably 4 Unknown A Theroschotic Cardionascur Disease 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendil within 24 hours efter death.
To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Placa of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29b. Signeture and title of cartifier 29d. Date signed (Month, Day, Year) 29c. License number Monte Masono, MD D-44783 september 7, 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MONTE MAKOUS West High STREET ELKTON, MD 21921 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State SEP 0 8 1998 Registrar

loniss, Carrol

Jan . William omist masketen Album Abo 98-4870-027 DDG 4 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #4b Per MEO Film G763 9-17-98RC

State of Maryland / Department of Health and Mental Hygiene Certificate of Death MARK LEE 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 0005 AM 20, 1998 Mark J. Lee AUGUST /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street end number) 4c. County of Death Examiner ROUTE 295 HOWARD | CULUMBIA, Plans | File | Fil 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Steta or Foreign Country) **Funeral** XXM 20F 44 355-76-7651 Director Jan 23,54 Korea Usual Residence of Decedant the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits must be notified at Md 1 X Yes 2 ☐ No Howard Directo Ellicott City 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 3110 Wheaton Way, Apt. A 21043 U.S.A. death Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2√ No If Yes, Give Year or Datas: the Medical Examiner in Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. Biack, White, etc. 1 Never Married 2 ☐ Married 1□Yes 2□No Maryland 21215-0020 Specify Specify: Korean þ 3 Widowed 4 Divorced "natural" Completed 16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Writer Editor other 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be in Department of Health and Mental Important: If item 27 is marked or Yi Yung Ho Yang Yi Juang 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) of Health Paul Lee (Son) 3110 Wheaton Way, Apt. A, Ellicott City 21043 other Baltimore, 20b. Place of Disposition (Neme of cematery, crematory or other plece) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or Meadowridge Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 8-26 Elkridge, Md. 21075 22. Name and Address of Facility Phillip Bell Fun. Ser. eral Service Licensee 4902 Stan Haven St., Temple Hill, Md. 23a. Part. Egrar the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** Immadiata Causa (Final disaase or condition resulting in death) /Medical MULTIPLE INJURIES Examiner Dua to (or as a consequanca of) Examiner thet the death certificate be executed the buriel-trensi Sequantially list conditions, if any, laading to immediate cause. Entar Underlying Causa (Disease or injury that initiated avants resulting in death) Last Dua to (or as a consequence of). Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): 88 use 20 Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? á 3 □ Probably 4 Dunknown 1 Yes 2 No signed t by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy periormed? completion of cause of death? hes page 2 1 □ Nas 2 □ No Yes 2 No certificete director, Be 25. Was case referred to medical axaminar? 26. Place of Death (Check only ona) Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 2 fXXYas 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Data of Injury (Month, Day Year) 8-20-98 28d Describe how injury occurred Stir IECT PASSENGER OF VEHICLE EXITED VEHICLE TO ROADWAY & STRUCK BY ANOTHER VEHICLE 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? A After 5 Panding investigation 1 Natural 12:04 a Hospital or Attandin 24 hours efter death. • Funeral Diractor: Aft 1 Yes 2 🗓 No 2 Accident 3 Suicida 6 Could not be datarmined 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) ROUTE 29 S. AT filled in by 4 Homicida STREET

JOHNS HOPKINS ROAD, COLUMBIA, HOWARD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

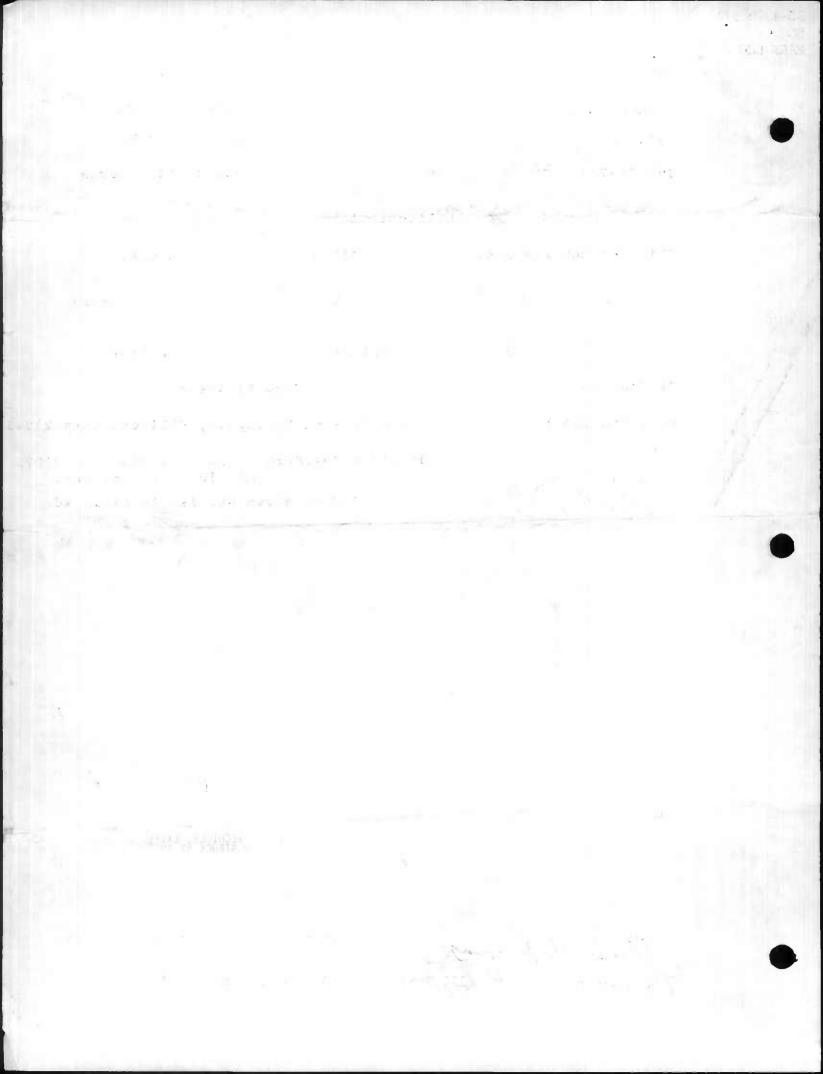
\*\*Columbia A. Howard

\*\*Columb edicai 29a. Certifier To the Within 2 29d. Date signed (Month, Day, Year) 29c, Licansa number 29b. Signature and title of certifier O.C.M.E. AUGUST 20, 1998 30. Name and addrass of person who completed cause of death (Itam 23a) (Type, Print) HEUDONE MIKING 111 Penn Street, Baltimore, Maryland 21201

State Registrar Date filed (Month, Dey, Yaar)
SEP 1 7 1998

32. Registrar's Signature

9. Sparks

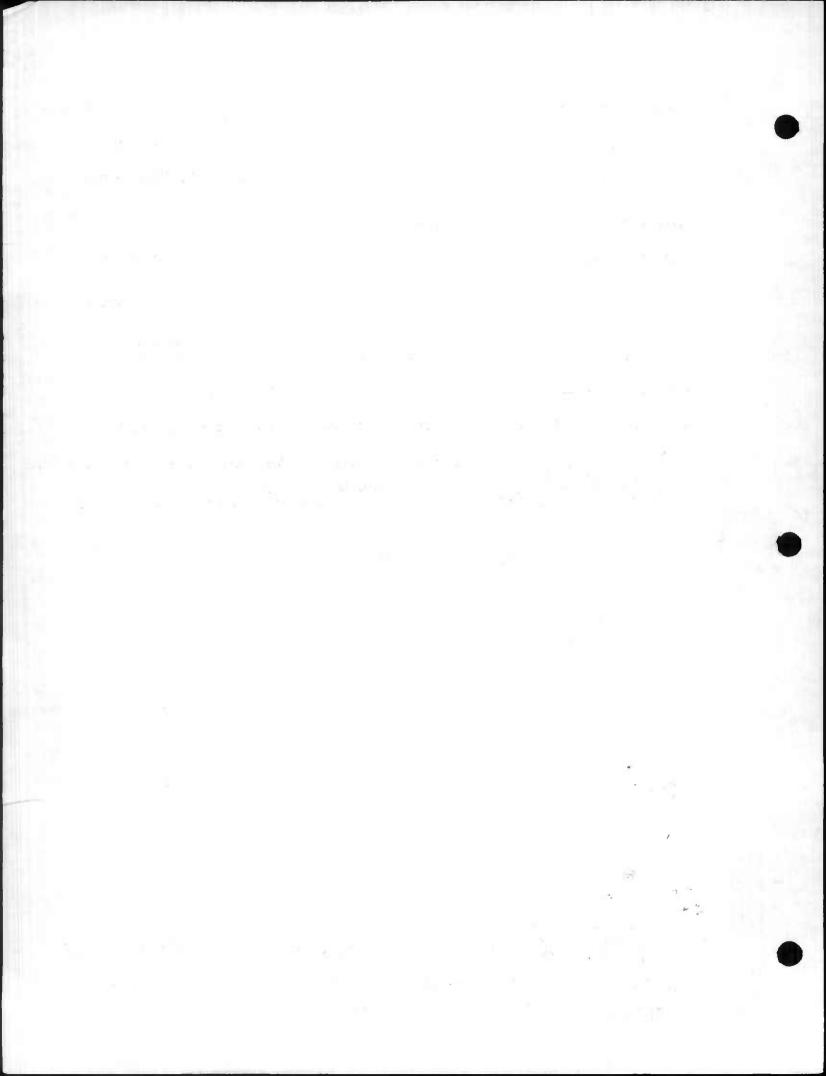


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State of Maryland / Department of Health and Mental Hygiene

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	or 28	Director	10e. Street end Number					Zip Code			10g. Citizen of \	What Cou	ntry?
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5-0		eted	15. Decedent's E (Specify only highest gra	ducation		16a. Dec	cedent's Us	sual Occup	pation	rkina	16b. Kind of Br	usiness/In	dustry
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m	Pages nent of I int: If Ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special						tion Cem.	Sept. 2	Cherry	H-11	, Maryland
Baltimore,	permit. Page: Depertment o Important: If I any injury or once.		21. Signature of Funeral Service Licer	196)	7		22. Name	and Addre	ess of Facility		Cherry	HITT	, maryland
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	/Medicai Examiner		Immediete Cause (Final disease or condition resulting in death)	a. G/1	106	asto	Duna						2 months
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39 )	5 00	Med	resulting in death) Last									i	
Box	eath cer ettendir for use	lan		d									
	the e	Physician/	Part II. Other significant conditions of	ontributing to death b	out not res	ulting in the	underlying	g ceuse giv	ven in Part I.	23b. Did t	obacco uae co	ntribute to	o the cause of death?
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COL		Completed									med?	ev	ellable prior to empletion of cause
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0	g Ph er thi		27. Manner of Death	28a. Date of Inju	ıry	28b. Time	of	28c. Injui	ry et	28d. Describe h			<i>y</i> /
Ö	Attending or death. ector: After by the fune	atic	1 Natural 5 Pending Investigation		,, , , , ,	Injury	М		Yes 2 □ No				
Division of	of or Attend efter death Director: /	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, et	jury - At ho	ome, farm, s	street, facto	ory, offica		28f. Location (S City or Tow	treet and Numb n, State)	er or Rure	al Route Number,
_	To the Hospital or Attending Physician: whithin 24 hours effect death.  To the Funeral Director. After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Ph	ysician: To the best	of my kno	wledge, dea	ath occurre	d at the tir	me, date and place	, and due to the d	ause(s) and ma	nner as s	tated.
	the H hin 24 the F	Medicai	0107	niner: On the basis o and manner st	ated.	don and/of							
	CON Wife	~	29b. Signature and title of certifier	6				9c. Licens			29d. Date signed		
			W. Yar	Mas, N	17			110	)14		41 cmb	41,	1998
	10		30. Name and address of person who		/	A	e, Print)	· -1-	303 8	ilVto.	md -	103	,
	- 540	to	31. Date filed (Month, Day, Year)	// WeST 22. Registr	-	sh S	1 0	wite	2013	IKTON,	110.0	1721	1
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State of Maryland / Department of Health and Mental Hygiene Items: 27,28a-f per MEO G-764 1/22/98 Gertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** August 27, 1998 10:35 am PERCIVAL GRANVILLE MELBOURNE, JR. ' /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Dey, Year) If Under 1 Year 7. Age (In yrs. lest birthday) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** 1∏M 2□F Months Days Hours Min Yrs. 578-46-9925 87 Director Oct 16, 1910 Maryland Usuel Residence of Decedent the Maryland 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 28a-f show 1 ☐ Yes 🏋 No Directo Maryland Oueen Anne Stevensville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 202 Oueen Anne Club Drive 21666 USA Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Bleck, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7: th and Mantal Hygiene. 7 Is marked other than "nu Grade 12 College (1-4or 5+) Engineer D.C. Highway Dept. 18. Mother's Name (First, Middle, Meiden Sumeme) 17, Fether's Neme (First, Middle, Last) Percival G. Melbourne Marguerite Chew 19e. Informant's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 st Depertment of Health and Important: if item 27 is n any injury or other traun 202 Queen Anne Club Drive Stevensville, Md. 21666 Percival G. Melbourne, III/son Baltimore. 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Aug 31, N Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Md. National Memorial Pk.1998 Laurel, Maryland 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 21. Signature of Funeral Society Licensee 20707 313 Talbott Avenue Laurel, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final rens urp disease or condition resulting in death) Examiner Due to (or as e consequenca of) Examiner asp Preymonia clation physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or as e consequenca of): cight hip Box 68760 cartificata be Physician/Medicai Due to (or es e consequence of): usa as for ed by tha e Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown 21 by 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24e. Was en eutopsy performed? Completed has 1 Yes 2 No 1 Yes 2 No cartificate Division of Vital director. 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) 1 Yes 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Impatient 2 ER/Outpatient 3 DOA 10 funeral 27. Manner of Deeth 28d. Describe how Injury occurred 28e. Date of fnjury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Certification: After 5 Pending investigation 1 Avatural 2 Accident daath. 1 Yes 2 No Aug.17,1998 UnknownM Subject slipped & fell after death Director: / 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) Stevensville, Md. 6 ☐ Could not be 3 Suicide 6 4 Homicide 202 Queen Anne Club Dr. Hospital of 24 hours at Funeral D Home Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the ceuse(s) and manner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end place, end due to the ceuse(s) end manner stated. 29a. Certifier edical (Check only one) To the To the To the 29b. Signarule and title of opstitler 29c. License number 29d. Date signed (Month, Dey, Year) 8 9 M.D 2 ell 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #309 HD 21403 31. Date filed (Month, Day, Yeer) 32. Begistrar's Signeture AUG 2 8 1998 Registrar

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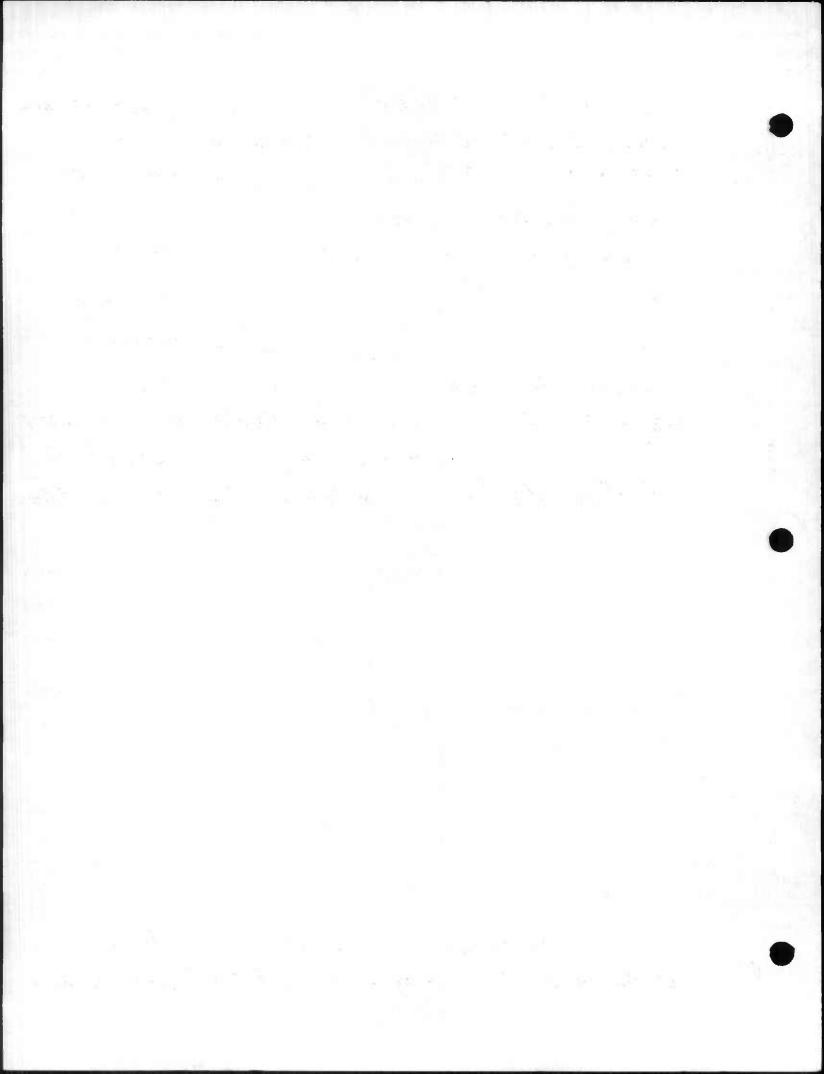
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DHMH 16 Rav 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middle, Lest) 2. Date of Death 3. Tima of Death Month **Physician** Sept. 1998 Ethel Grace McMullen 8:17 PM /Medical 4e Facility Nema (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Yaar If Under 24 Hrs. 8 Data of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) 6 Sex Birthplace (Stata or Foreign Country) **Funeral** Days 1 M 2 F Months Director 215-32-4128 85 1913 Maryland Usual Rasidance of Decedant 10a. Stata 10b. County 10c City Town or Location 10d Inside City Limits 1 Yes 2 No Directo Maryland Cecil Perruville 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 542 Evans St. 21903 LISA 12. Was Decedant Evar in U,S. Armad Forcas? 1 ☐ Yes 2 ☒ No If Yes, Giva Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, 11. Marifel Status Black, Whita, atc. 1 Nevar Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: "natural", or Specify: White þ 3 Ø Widowed 4 □ Divorced 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) Collega (1-4or 5+) Public Schools Dishwasher 17. Father's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Sumama) Be and 2 should be selfth and Mental Edson Burkins Marietta Curry 19e. Informent's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Department of Health a Important: If Item 27 It any injury or other tra 542 Evans St. PO Box 266 Perryville, MD 21903 John L. McMullen/Son 20b. Plece of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burlel 2 Cramation 3 Ramoval from Stata 9-5-98 4 ☐ Donation 5 ☐ Othar (Specify) Brookview Cemetery Rising Sun, Maryland 22. Nama and Addrass of Facility
R. T. Foard Funeral Home, P. A.
111 S. Queen St., Rising Sun, Maryland 21911 21. Signature di Fundirai Syffrice Ule 00 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disaasa or condition rasulting in death) /Medical · ACUTE MYOCARDIAL INFARCTION FEW MINUTES Examiner CFIVE MIN Examine CORONARY ARTERY

Dua to (or as a consequence of): DISEASE - FOUR YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaese or injury that initiated evants resulting in death) Last Physician/Medical Due to (or es e consequence of) Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CEREBROVASCULAR ACCIDENT 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? Be 26. Place of Deeth (Check only one) To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) TYPES 2 No this 28a. Data of fnjury (Month, Dey Year) 27. Mennar of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Netural 2 Accident 5 Pending investigation death. 1 Yas 2 No n 24 hours after death.

The Funeral Director: A pletaly filled in by the filled in by the filled in the filled in by the fil 6 Could not be detarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28a. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 10 Certifying Physician: To the best of my knowledge, daeth occurred et tha time, data and place, and due to tha cause(s) end menner as stated.
2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signeture end fitla of certifie wellher fam or O 4 30. Name and address of person who complated cause of death (Item 23a) (Type, Print)

State Registrar SURESH DHANJANI, MD

SEP 0 2 1998

31. Data filed (Month, Day, Year)

1998

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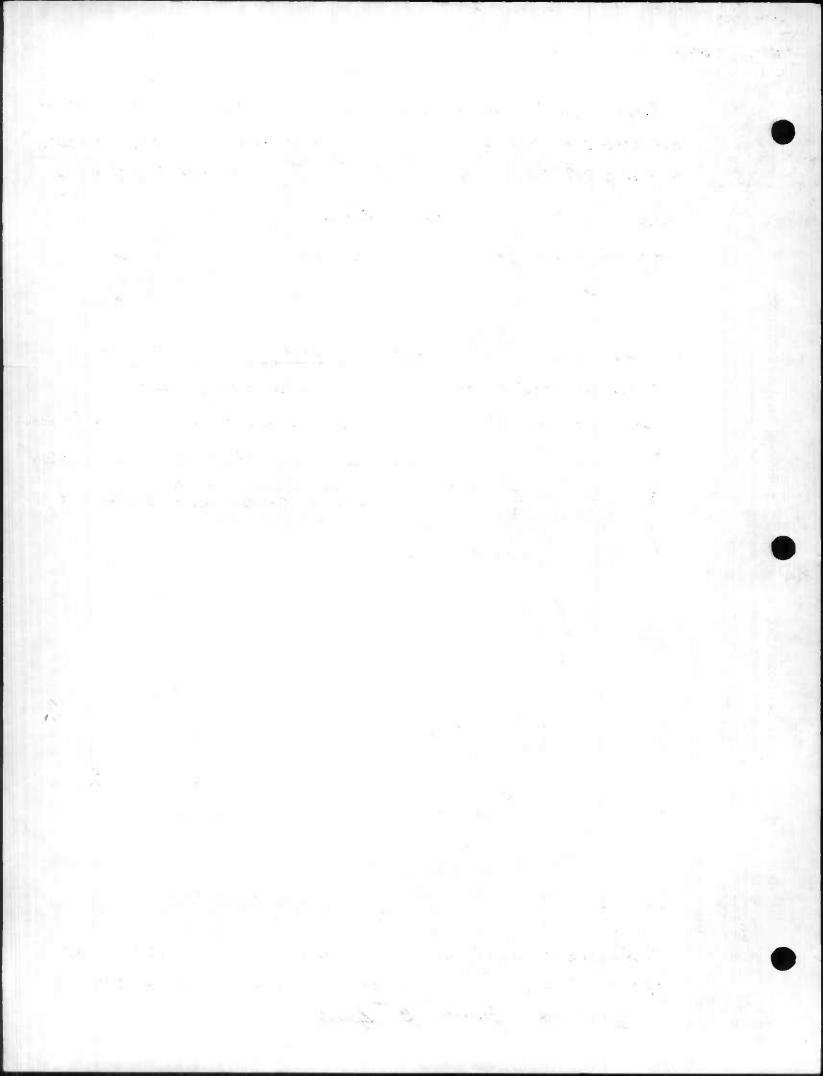
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1D, 20 CRAIGTOWN RD, PERRYVILLE MD 21903 32. Registrar's Signature

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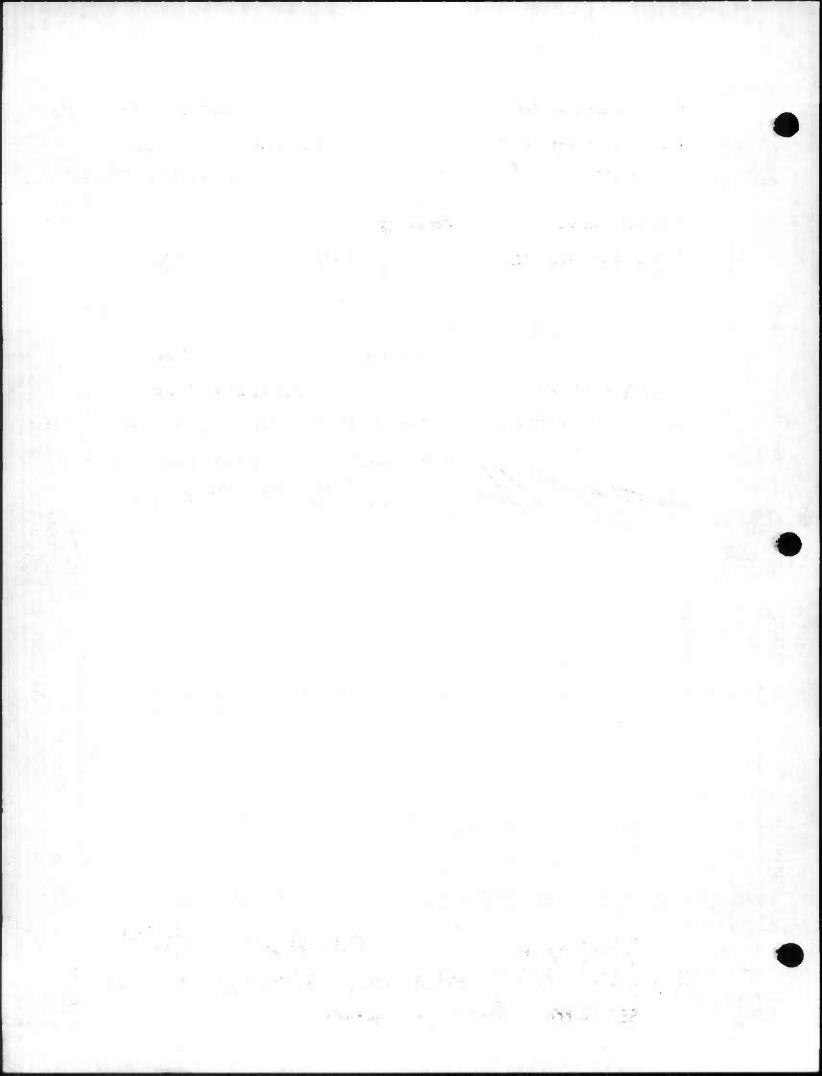
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Examine	"			HOSPITAL				HAGERSTO	3		NGTON COUNTY
uneral rector	_	5. Social Sacurity	Number 6. S				Inder 1 Year nths Days	If Under 24 Hrs	8. Date of Birth	Year)	9. Birthplace (State or Foreign Country)
ž ==	-	Usual Residence of 10a. State	10b. County		10c. City	, Town or Location	n				10d. Insida City Limits
23a or 28a-f show ust be notified at	tor	mp.			H	992137	lowa	/			1 ☐ Yes 2 ☐ No
or 28a	Director	10e. Street and Nu	ımber			10	f. Zip Code		1	0g. Citizen of V	What Country?
Net must b	la l	261	Willer.	d st.			217			U.	
	by Funeral	11. Marital Status  1 □ Never Marriad  2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever Armed Forces?  1 □ Yas 2 □ No If Yes, Give Year or Datas:				If Yes	Decedent of specify Cut	Hispanic Origin? (Span, Mexican, Puer Specify:	pecify Yas or No- to Rican, atc.)	Biad	e - American Indian, ck, White, etc.
			15. Decedent's E	ducation		16e. Decedent's	Usual Occu	pation			usiness/industry
the Med	Completed	Elementery/Secondary (0-12) College (1-4or 5+)						during most of wo	rking		1516
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ner		disease or conditi resulting in death)	on	a. ARTERIOSCI		as a consequenc		DISEASE			
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cartificate has ractor, page 2	E								1 KY	es 2 No	1 Yes 2□ No
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8 8 8	Certification:	27. Manner of Dea 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide	th 5 ☐ Pending investigation 6 ☐ Could not b		ly Year)	28b. Time of Injury		]Yes 2□No	28d. Describe h		
tha fun	=	4 ☐ Homicide	determined	building, a	tc. (Specify				City or Tow	n, State)	per or Rural Route Number,
lled in by tha fun			1 Certifying Ph	ysicien: To the best	f examinati						anner es steted. and due to the cause(s)
To the Funeral Director: After complataly filled in by the funer	edical	29a. Certifier (Check only one)		and manner si	ated.						
complataly filled in by tha funaral	edical	(Check only	2⊠ Medical Exar	and manner si	ated.		29c. Licen	se number	2	9d. Data signe	d (Month, Day, Year)



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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ical	1	Helen Will						41 01 -	Augu	st	30 1	998	1:08 PI
ner		la. Facility Neme (If not 1105 Liber			oar)				, or Location o	Death	4c. County		
	5	5. Social Security Numb	er 6. S	ex 7.	Age (In yrs.	. lest birthday)	If Undar 1 Year Months Devs	If Under 24		of Birth th, Day, Y	Cec		ca (Stete or Foreig
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	-	Usuel Residence of Dec 10a. Stete 10b	b. County		10c. Ci	ity, Town or Loc	cation					100	d. Inside City Llmits
tor	5	Maryland	Cecil		C	onowing	10						1 ☐ Yes 2 No
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rail		1105 Liber	ty Grov				2191	8			USA		
by Funeral Director	5	11. Maritel Status 1 ☐ Naver Married 3 ☐ Widowed 4 💢		12. Was Decede Armad Force 1 Tes 2 If Yes, Give Yaar or Date	es? [X]No	If	Vas Dacadant of H Yes, specify Cub	an, Mexican, F	? (Specify Yes Juarto Rican, a	or No-		ck, White, et	c.
		15.	Decedent's Ed	fucetion		16a. Deced	ent's Usuel Occup kind of work done OO NOT use retire	pation	working	16	ib. Kind of B		
Completed		Etementary/Secondary		College (1-4	or 5+)			d)	Working				
		7. Fathar's Name (First	t, Middle, Last)	2		Secre	tary	18. Mother's	Name (First, M		hemica		
To Be		J. Bradford	d Willi	.ams					Isabel				
	1	19e. Informent's Name/				19b. Mailin	g Address (Street						Code)
	-	Mary I. Rac		ughter			Liberty		1				and 21918
	2	0a. Method of Disposition 1 □ Buriai 2 □ Cra		Removei from St	BIG		sition (Neme of netory or other ple	-	Date		c. Location -		
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item 26, per Phy. 9/3/98, Carroll County, wil Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death STACK 13:47=H /Medical tb. City, Town, or Location of De Examiner WESTMINSTER 12M 20 F Days Hours Director the Marylenc 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23a or 28a-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MINSTS 10f. Zip Code 10g. Citizen of What Country? 211 by Funeral death 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) merican Indian 11. Maritel Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 72 th and Mental Hygiene. College (1-4or 5+) adary (0-12) NURSING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 150 permit. Pages 1 and 2 Department of Health a Important: if item 27 is Frack 558 FRINKINGST WAS PARTY OF THE PROPERTY OF THE PROPERTY OF OTHER PLACE CARDENS 8/29/98 SCAN paughtor other 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) 0 any injury 21-Gignature of Funeral Service Licensee PRITES FUNERAL HOME & Chapel 412 WAShINGTON PO WESTMINSTER, NO. 21157 23a. Part 1) Enter the disease, or complications that ceused the death. Do not enter the mod should, or heart failure. List only one cause on each line. **Physician** /Medicai Immediate Cause (Final disease or condition resulting in death) Examiner Examiner 1 tenses the buriel-transi Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last to (or as a consequence of) pue Division of Vital Records, P.O. Box 68760 physicien Physician/Medical Due to (or as e consequence of) usa as signed by the a 23b. Did tobecco use contribute to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Wes en autopsy performed? Completed 2/2NO 1 Yes 2 No if or Attending Physician: aftar death. Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Statement 6 Other (Specify) 1 Yes ZNO 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Netural 2 Accident 5 Pending Investigation 1 Yes 2 🗆 No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier edical (Check only one)

State

31. Date filed (Month, Day, Year)

30. Name and address of person

29b. Signature and title of certill

SEP 0 3 1998

FRE 151

295 32. Registrar's Signature

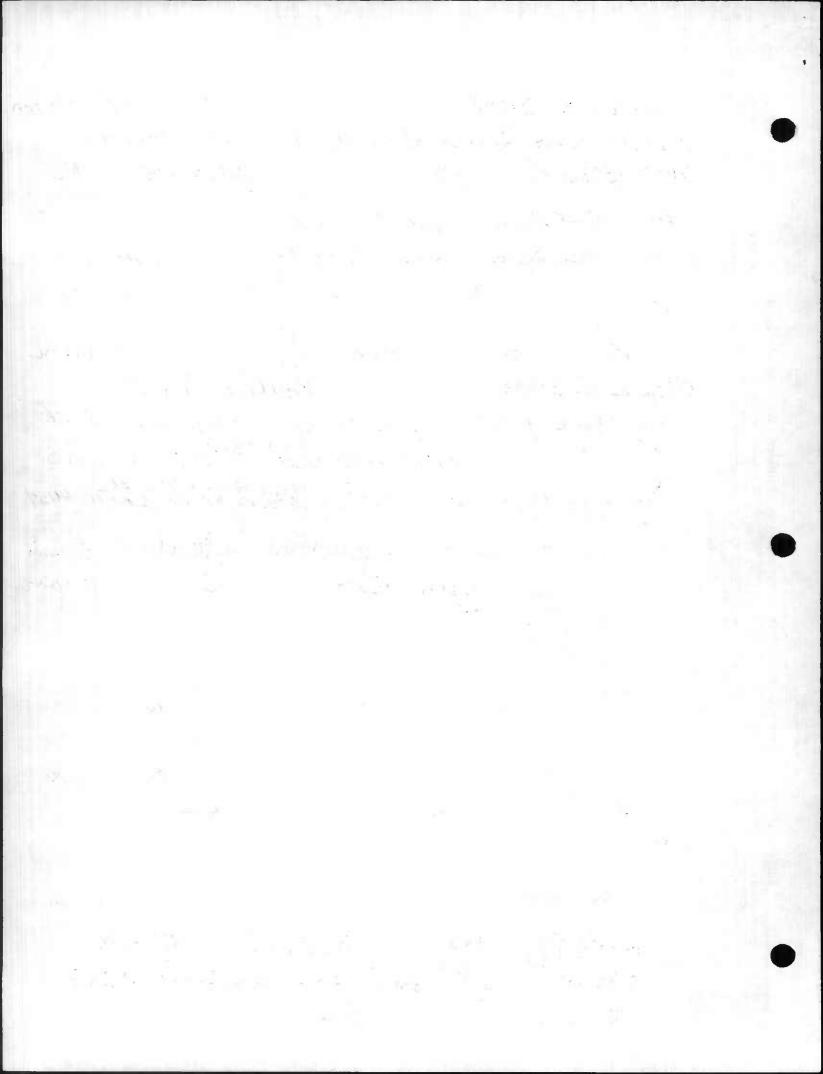
pleted cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

4 lestruustes 21157

Registrar



### Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Year Month Robert September 1, 1998 cation of Death 4c. County of Death Sadler Leroy 7:13 AM 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death Havre de Grace Harford Memorial Hospital Harkord If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) 10 M 2□ F Yrs. 577-09-1292 87 12, 1910 Pennsylvania Usual Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yas 2 No Maryland Calvert Sunderland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? PO Box 235 20689 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black White atc. 1 Nevar Married 2 Married 1 Yas 2 No Specify: Specify: 3 Nidowed 4 Divorced Yaar or Datas: White 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Service Manager Office Equipment 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Roy L. Sadler Susan E. Bear 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mary Ann Uhlan/Daughter PO Box 235 Sunderland, Maryland 20689 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 Donation 5 □ Othar (Specify) Glen Haven Memorial Park 9-4-98 | Glen Burnie, Maryland 22. Name and Addrass of Facility R. T. Foard Funeral Home, P. A. 21. Signature of Funeral Sarvice Licenses cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate icharo 23a. Part 1. Entar tha disaasa, or complication shock, or haart failura. List only ona cay Approximata Intarval Between Onset and Death Immediate Causa (Final disaasa or condition rasulting in death) Dua to (or as a consequence of) ASPIRATION Sequentially list conditions, if any, laading to immadiata causa. Enter Undarlying Cause (Diseasa or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown Confestivh HART PAILBRE 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? ACAARMIS 2000 1 Yes 22 No 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only one) Hospital: 12 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas ZNO 27. Mannar of Death 1 | Natural 2 | Accidant 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding invastigation 1 ☐ Yas 2 ☐ No

Physician/Medical tha Be Completed by Medical Certification: To Division Attending 24 hours after deat Funeral Director: complataly filled in by 6

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

Completed

**Funeral** 

**Director** 

b

Pages 1 and 2 should

timore.

Department of Health Important: If Item 27

Physician /Medical

Examiner

To the I within 2 4

29b. Signatura and titla of

3 Suicide

29a. Cartifier

4 Homicida

(Check only one)

31. Date filed (Month, Day, Year)

State Registrar

**DHMH 16 Rev 6/95** 

SEP 0 2 1998

TONDO

6 Could not be datarmined

30. Name and address of person who complated cause of death (Item 23a) (Type, Print) 32. Ragistrar's Signatura

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

Certifying Physician: To tha best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 | Medical Examiner: Of the best of ny knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

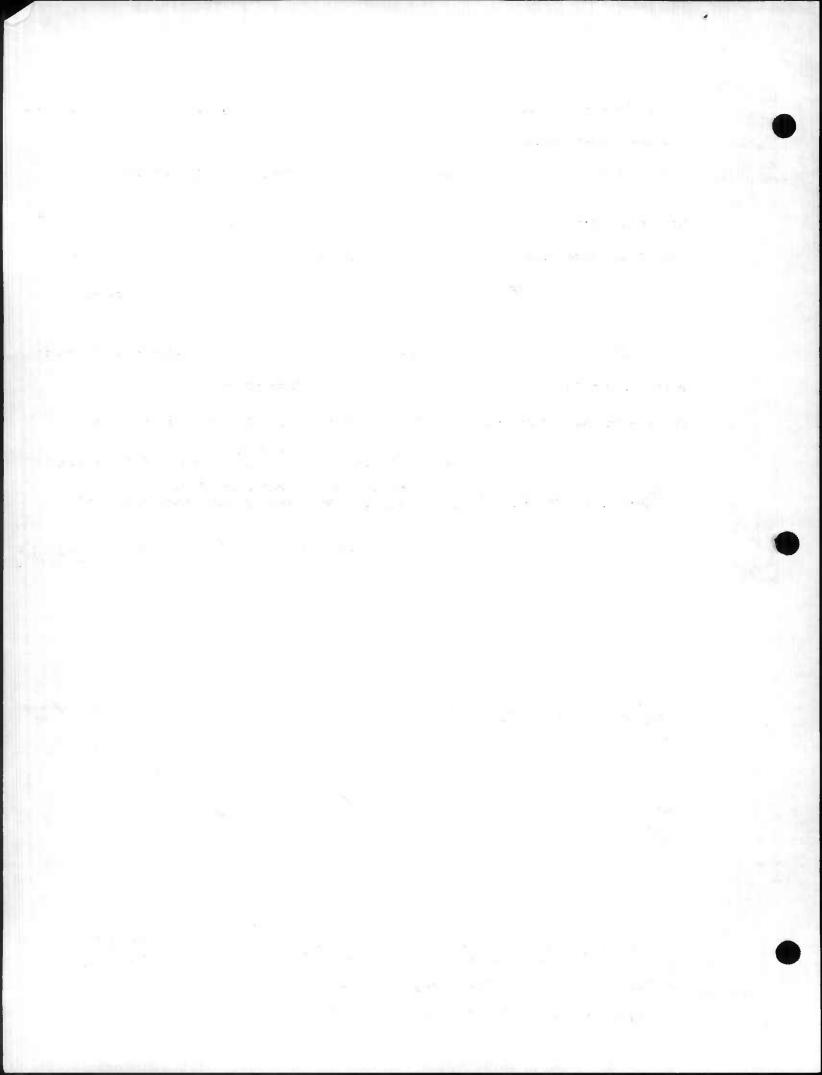
29d. Data signed (Month, Day, Year)

**ORIGINAL** 

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	-	- 7	Decedent's Neme (First, Middle,	Last)		Cer	tificate	of I	Death	2. Dete of Dee	Reg. No.	2.8	3. Time of Deeth
п	Physic		Walter Leonard T							Month	Day	Yeer	
	/Medi		4a. Fecility Name (If not institution,	-	er)				b. City, Town, or I	August	29, 19		10:59 a
-4	Examir	ıer	409 Black Snake		iumbery				Elkton		Cecil		
H	Consent				Age (In vrs.	lest birthday)	If Under 1	1 Year	If Under 24 Hrs.	8. Date of Birt			ace (State or Ecraion
L	Funeral Director		222-16-0677  Usuel Residence of Decedent			Yrs.	Months	Deys	Hours Min. Septe	(Month, De)	v, Year)	Counti	ece (Stata or Foreign ry) are
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	the N	Director	Maryland Cecil  10e. Street end Number			Elkt							
	with of	Di					10f. Zip (				10g. Citizen of		
	eath m 23	era	409 Black Snake	12. Wes Decede	nt Francis II	C 10 V		1921		if - W NI-		ed Sta a - America	
020	ours efter d al', or item Examiner	by Funeral	1 □ Never Merrled 2 □ Married 3 □ Widowad 4 ☑ Divorcad	Armed Force	s? No		Yas, specif		ispenic Origin? (S) an, Mexican, Puarti Spacify:	Rican, etc.)		ck, White, e	tc.
21215-0020	within 72 hours efter death with the Maryland jiene. Than "natural", or items 23s or 28s-f show the Heusel Evantue mail be notified at		15. Dacadant's Education (Specify only highest grede completed)  Elamantary/Sacondery (0-12)  Collaga (1-4or 5			(Give lifa. L	OO NOT use	done d retired	during most of wor	king	16b. Kind of B		
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Maryland	ad la b	To Be	Harry M. Temple	5.7					Anna F	ritz			
Jar	2 2 2 2		19e. Informent's Neme/Ralationship						end Number or Ru				
	1 end 2 Health em 27 l		William Entenman	n/ friend	7				ce Road,				
Baltimore,	pemil. Pages 1 and Department of Health Important: If item 27 any injury or other to once.		20a. Method of Disposition		te	Place of Disposementery, crem	etory or oth	ner plec	Augu	Date 1st 31,	20c. Location		
Balti			21. Signeture of Funerel Sarvica Lic	ensee	511	22	Neme end	Addres	ss of Fecility  for Fune			11, 140	ilyland
			23a. Pert 1. Enter the diseasa, or co	8. Hich	Ras	10	3 West	t St	cockton,	Elkton,	Maryla	nd 219	921
	Physician /Medical Examiner	ner	Immediate Cause (Final disasse or condition resulting in deeth)	. arte	Due to (d	CLUTOL or es e consag		ar	diovas	cular	diseas	e u	Intervel Betwaen Onset end Daath
68760,	ificate be executed g physician end es the bunel-transit	edicai Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in daeth) Last	b		or es e consequ							
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Records,	aw requi	Completed t	/ /							24a. Wes e	en autopsy med?	com	a eutopsy findings lebla prior to pletion of causa aeth?
<u> </u>	The ste h	Con								1 🗆 Y	es 20 No	10	Yes 2 No
Vital		Be (	25. Was case rafarred to medicel examiner?					/	26. Plece of Dea	th (Check only or	na)		
of V	2 00	2	1 Yes 2 No	Hospital: 1 🗆 Inpa	itient 2	ER/Outpetient	30 00A	Othe	er: 4 Nursing H	ome 5 Rasid	enca 6 Oth	er (Specify)	
ouo	Attending Ph or death. ector: After th by the funeral		27. Manner of Deeth  1 Naturel 5 Pending 2 Accident investigat		njury De <i>y Year)</i>	28b. Time of Injury	M 286	c. Injun Work	/ et ⟨? Yes 2 □ No	28d. Describe h	ow injury occur	red	
Division	F P F Q	Certification:	3 Suicide 6 Could not datarmine	200. Placa of I	Injury - At he etc. (Specif	oma, farm, stre	et, factory,	offica		28f. Location (S City or Tow		per or Rural	Routa Number,
	he Hospital in 24 hours he Funeral pletely filled	edicai	29a. Cartifier 1 Certifying F (Check only one) 2 Medical Ex	Phyeiclan: To the bas aminer: On tha basis end manner	of exemine	wledga, daath tion end/or lnv	occurrad et estigetion, in	tha tim	na, data and place, pinlon, deeth occur	and dua to tha d red et the time, d	ause(s) and mo lete end place,	ennar as sta and dua to t	ted. he ceuse(s)
	To the To the Comple	W	29b. Signature and title of certifier	elen U	1		29c.	License	1704		8/29	a akonen, D	ay, Year)
			30. Name end eddrass of person where Pat Weber M.D.			123e) (Type, F					1 1	, 0	-
	Sta		31. Dete filed (Month, Day, Year)		strar's Signe		1	1	,				

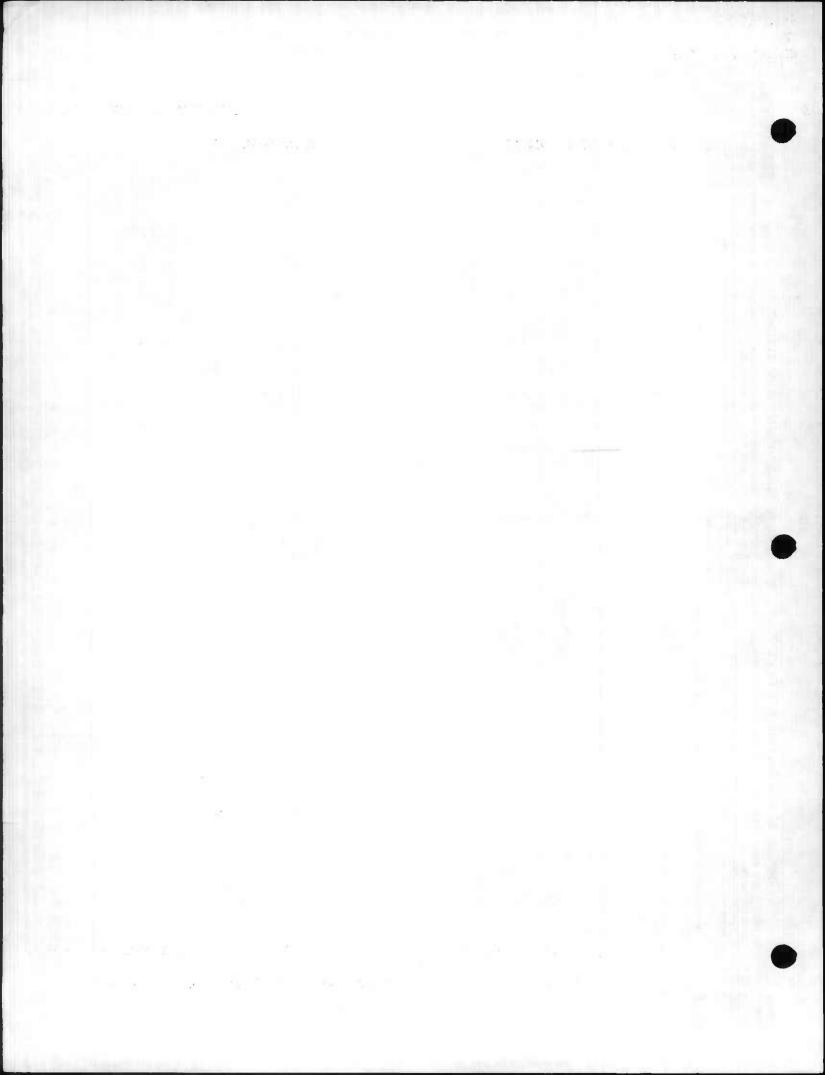
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cal ner	4e Facility Neme (i		E QUAN WH	ITE			4	b. City, Town,	AUGUS or Location of De	T 3,	1998 County of Deeth	0515	5 AM
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	Usual Residence of	Decedent  10b. County		10c Cit	y, Town or I	ocation			100116	12,		10d. Inside C	Ity Limits
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	10e. Street end Nu	WICOMIO mber	LU	I SA	LISBU		ip Code			10g. Citize	en of Whet Cou	intry?	
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Ì		9a. Informent's Neme/Reletionship (Type, Print)				ling Addre	ss (Street	and Number or	Rural Route Nur			ip Code)	
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I	20e. Method of Disp		Removal from State	20b. F	Place of Disp cemetery, cr	osition (N ematory o	lame of r other plac	:e)	Date	20c. Loc	ation - City or T	own, Stete	
l	4 Donetion	5 Other (Specif	y)	SP				GARDEN			IN, MD.		
	21. Signature of Fu	ineral Service Licer	A O	1					JOLLEY				
+	23a Parti Enfort	prella por com	plications/ t cause	ley d the deat	h Do not e	1213	JERSE	Y ROAD	SALISB	URY, M	D. 2180	)1 Approximat	to
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	thet initiated events resulting in deeth)		d	Due to (o	r es e conse	equence of	):						
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	27. Menner of Deat  1 🖸 Natural  2 🗆 Accident		28e. Date of Inju	iry	28b. Time Injury	_	28c. Injur Wor	4 LI NUISIII	g Home 5 Re 28d, Descrit	esidence 6 be how injury		ify)	
2 Accident 3 Suicide 6 Could not be determined 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									n (Street and Town, State)	Number or Ru	ral Route Num	n <i>ber</i> ,	
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	29b. Signeture end	title of certifier				2	9c. Licens	e number		29d. Date	signed (Month	, Dey, Year)	
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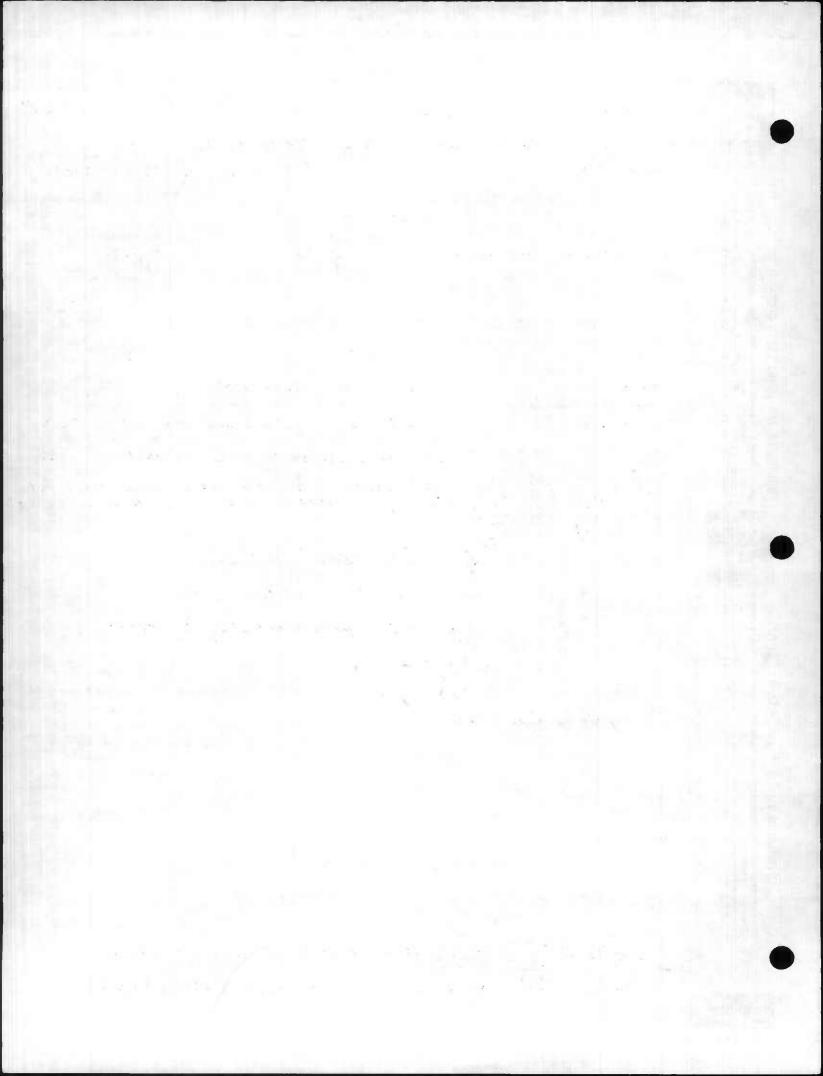


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State of Maryland / Department of Health and Mental Hygiene 🔾 🗬

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ter ber /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical System salpmore Marylan N/A| If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 0 5 / 2 0 / 1 9 6 0 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Months Deys 214-78-8538 38 Maryland Director Usual Residenca of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at MD N/A Baltimore 1 Ves 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 813 Dumbarton Avenue, #E 21218 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. nit. Pages 1 end 2 should be filed within 72 hours after enternent of Hatilth end Mertal Hyglena. ortant: If item 27 is marked other than "natural", or ite injury or other traumalt event, the Med. all Engines. Never Married 2 Married Maryland 21215-0020 1 Yes 2√ No Specify: Black by 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 86 Herbert Wesley Berkley, Sr. Erma Spell 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 3929 Frisby Street, Baltimore, MD Erma Spell Baltimore, 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Department of Important: If any Injury or page. Randallstown, King MemorialPark 9/21/98 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Liceurs 22. Name and Address of Facility LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO., MD21207 or complications that call d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one ceuse on eech line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Stage Rena disease or condition resulting in death) **Examiner** Examiner noxic/cschemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Dysto (or as a consequence of): P.O. Box 68760, emonun Physician/Medicai physi Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 probably 4 □ Unknown signed t Records, p 24b. Were autopsy findings evellable prior to completion of cause of death? 24e. Was en eutopsy performed? Completed peen page 2 1 ☐ Yes 25 No 1 Yes 2 No this certificate Division of Vital Hospital or Attending Physician:
 124 hours after death.
 Funeral Director: After this certifica director, 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 inpatient 2 ER/Outpatient 3 DOA luneral Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending Investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es steted. Medical 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the To the To the 29b. Signature and title of coeffici 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and add ed cause of death (Item 23a) (Type, Print) University of Maryland Medical ing M.D. 31. Date filed (Month, Day, Year) SEP. 18-1998 33 Hogistrar's Signature State Registrar

**DHMH 16 Rev 6/95** 



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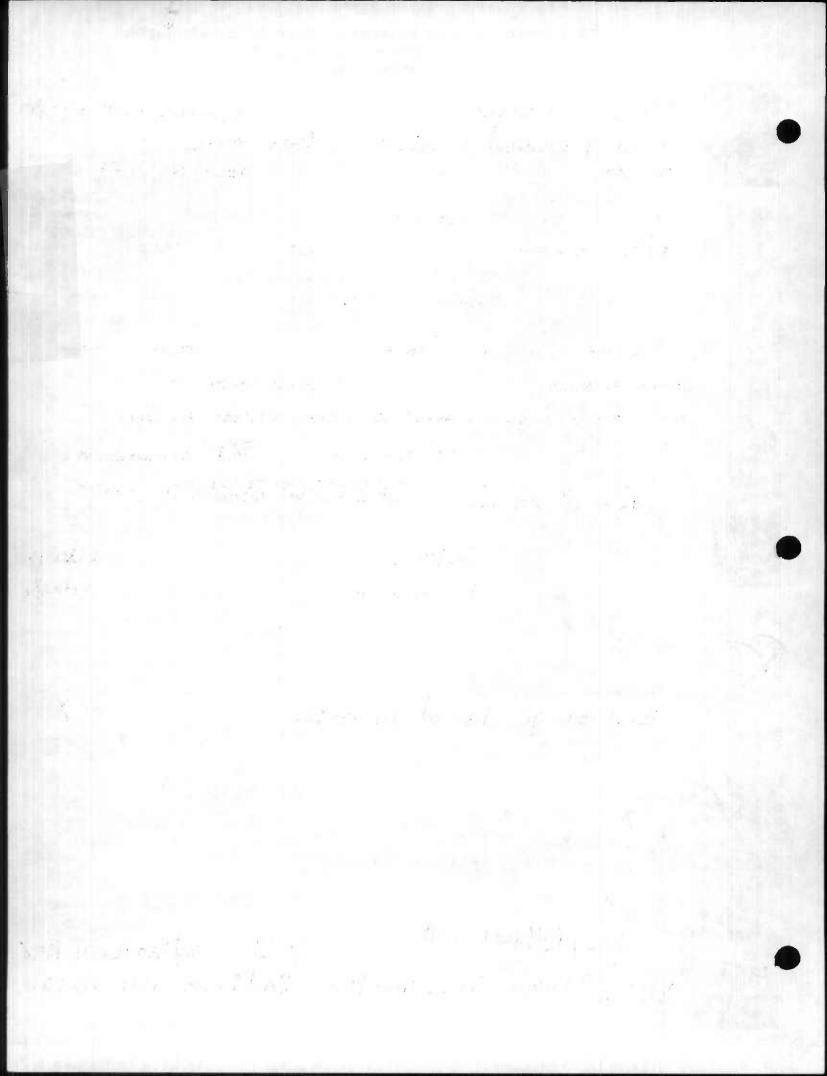
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** 4e Fecility Neme (If not institution, give straat and number) Schember 16 198

pr Location of Death 4c. County of Death 6.15 PM Barnes /Medical 4b. City, Town 4c. County of Death Examiner Ba Medy CO indus 16xcu If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Sept. 10 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplaca (State or Foraign **Funeral** 1 M 2 F Months Deys Hours Min 217-12-9924 74 Yrs. 1924 Maryland Director Usual Rasidance of Dacedeni the Meryland 10a. State 10b County 10c. City, Town or Location 10d. Insida City Limits ortant: If item 27 is marked other than "naturel", or items 23a or 28a-f show injury or other traumstic event, the Madical Examer must be notified at 1 Yas 2 □ No Director Md. n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21230 USA 611 S. Charles Street Funeral 12. Was Decedant Ever in U.S. Armed Forces? 1 to Yas 2 □ No if Yes, Giva 1943–45 Yaar or Datas. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Ham 27 is merked other than "natural", or free any injury or other traumatic event. 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No þ white 3 ☐ Widowed 4 10 Divorced Completed 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Fiamantary/Secondary (0-12) College (1-4or 5+) unknown unknown Guard State of Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Bernard S. Barnes Blanch Lee Hendrick 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Mary L. Barnes (Daughter-in-law) 833 Glade Court, Baltimore, Md. 21225 20a. Method of Disposition 20b. Placa of Disposition (Nama of cematery, cramatory or other place) 20c. Location - City or Town, Stete Sept. 21 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stata V.A. Crownsville 1998 Crownsville, Md. 4 Donation 5 Other (Specify) 22. Name and Addrass of Facility McCully-Polyniak Funeral Home 21. Signatura of Funaral Sarvica Licansas 130 E. Fort Ave. Baltimore, Md. 21230 lun 23a. Part1. Enter the disease, or complications that caused the daath. Do not antar tha mode of dying, such as cerdiac or respiratory errest, shock, or haar failure. List only one ceuse on each line. Approximeta Intarval Batween Onset and Daath **Physician** Immediata Causa (Final disaase or condition rasulting in daath) /Medical **Examiner** Dua to (or as a consequanca of): Examiner neumonia Sequantially list conditions, if eny, laading to immadiata ceusa. Entar Undarfying Cause (Diseese or Injury that Initiated avents rasulting in daath) Last and Due to (or as a consaguanca of) Box 68760 Physician/Medical Due to (or es a consequance of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 8 3 Probably 4 Unknown 1 Yes 2 No by 24b. Wara autopsy findings evellable prior to completion of cause of death? 24a. Was an eutopsy performed? Completed 1 Tyas 1 ☐ Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific 25. Was cese referred to medical axaminar? Be 26. Place of Daath (Check only ona) 1 Yas 2 No Hospital: Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpetient 3 DOA funeral 27. Manner of Deeth 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28c. Injury at Work? Medical Certification: 28b. Tima of 1 Natural 2 Accidant 5 Panding invastigation 1 TYas 2 No 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Thomicide 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifiar (Check only one) 29c. Licensa number 29d. Data signad (Month, Day, Year) 50853 30. Nama and eddress of person who complated ceusa of daath (Itam 23a) (Type, Print) Place Baltimore Pethkar 301 St. Paul ay 31. Date filat (Month, Day, Year) 32. Registrar's Signature SEP 1 8 1998 Registrar



P.O. Box 68760 certificate be Division of Vital Records, or Attanding Physician: effer death. Director: After this certifice

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29a. Certifier

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Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Unknown

29b. Signature and title of certifian Medicine Kesident

29c. License number

Beltimore MO

29d. Date signed (Month, Day, Year)

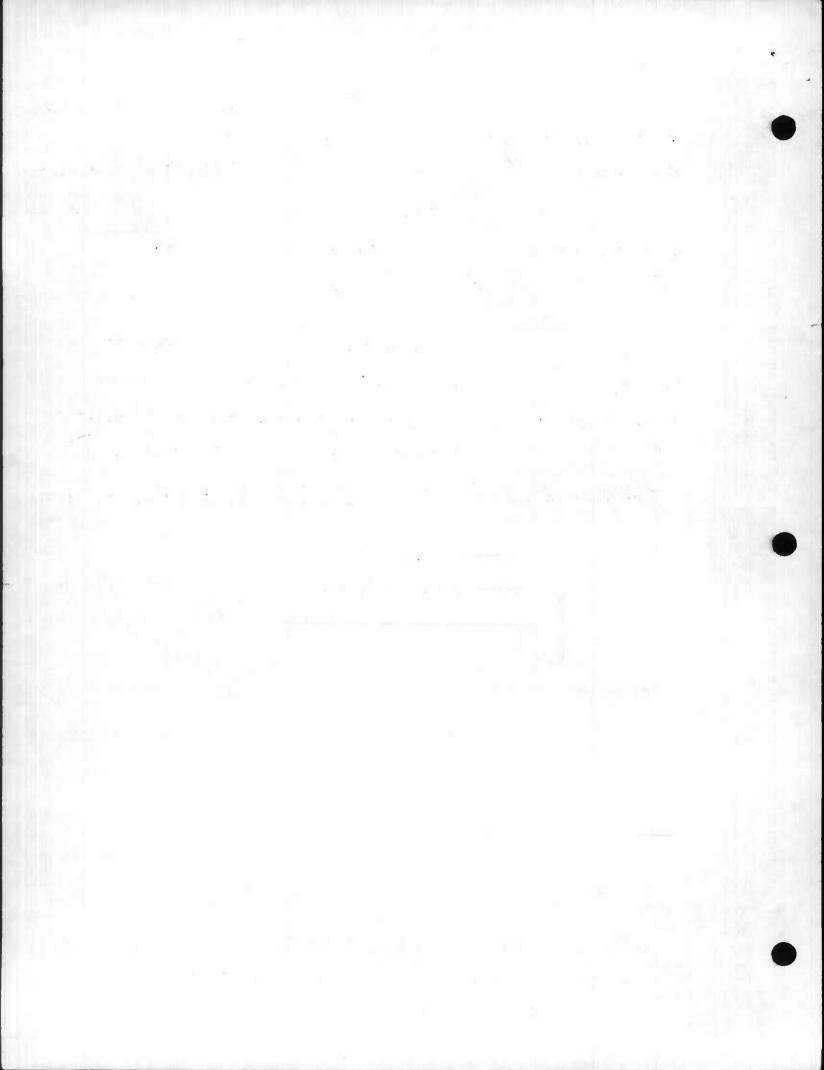
e and eddress pt person who completed ceuse of death (Item 23a) (Type, Print) North Wolfe Blankson

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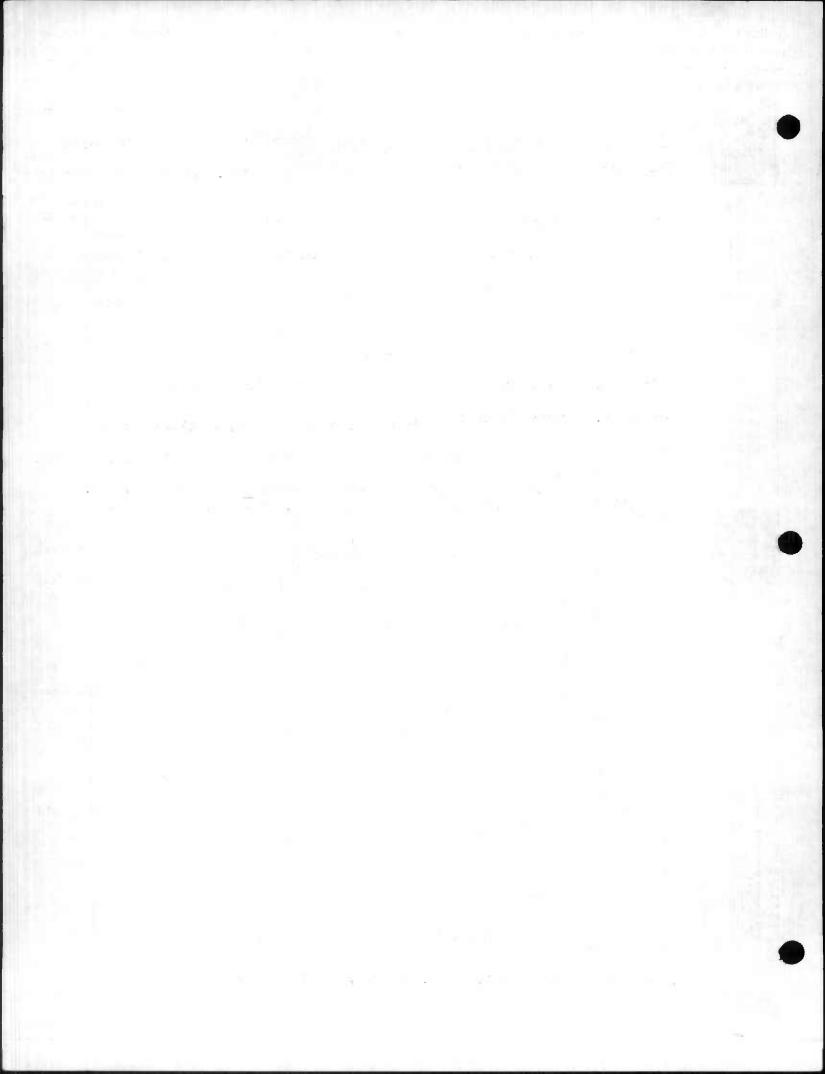
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al, or items 23s or 28s-1 show Examiner mast to notified at	by Funeral	1 Never Married 2 Married  3 Widowed 4 Divorced	Amed Forces?  1 Yes 2X No If Yes, Give Year or Dates:		f Yes, specify Cub	Hispanic Origin? (Spen, Maxican, Puart Specify:	o Ricen, etc.)	Specify	e - American Indien, kk, White, etc.	
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Department of Health Important: If Item 27 any Injury or other tr once.		20a. Method of Disposition  1   Burial 2 □ Cremetion 3 □ F  4 □ Donation 5 □ Other (Specify)	20b.	Plece of Dispo cemetery, cren	3 Eder Ro sition (Neme of netory or other ple Cemeters	oce)	alk, Mar	20c. Location -	21222 City or Town, State Tore, Marylan	. A
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Mours a	edical Ce	29a. Certifier 12 Certifying Physic (Check only one) 12 Medical Examination	aician: To the best of my kn	nowledge, death	occurred et the tir	me, date and place,	, and due to the c	euse(s) end me late end plece, e	nner as stated. end due to the ceuse(s)	
從生器	X	51.07	and manner statad.	1					1	
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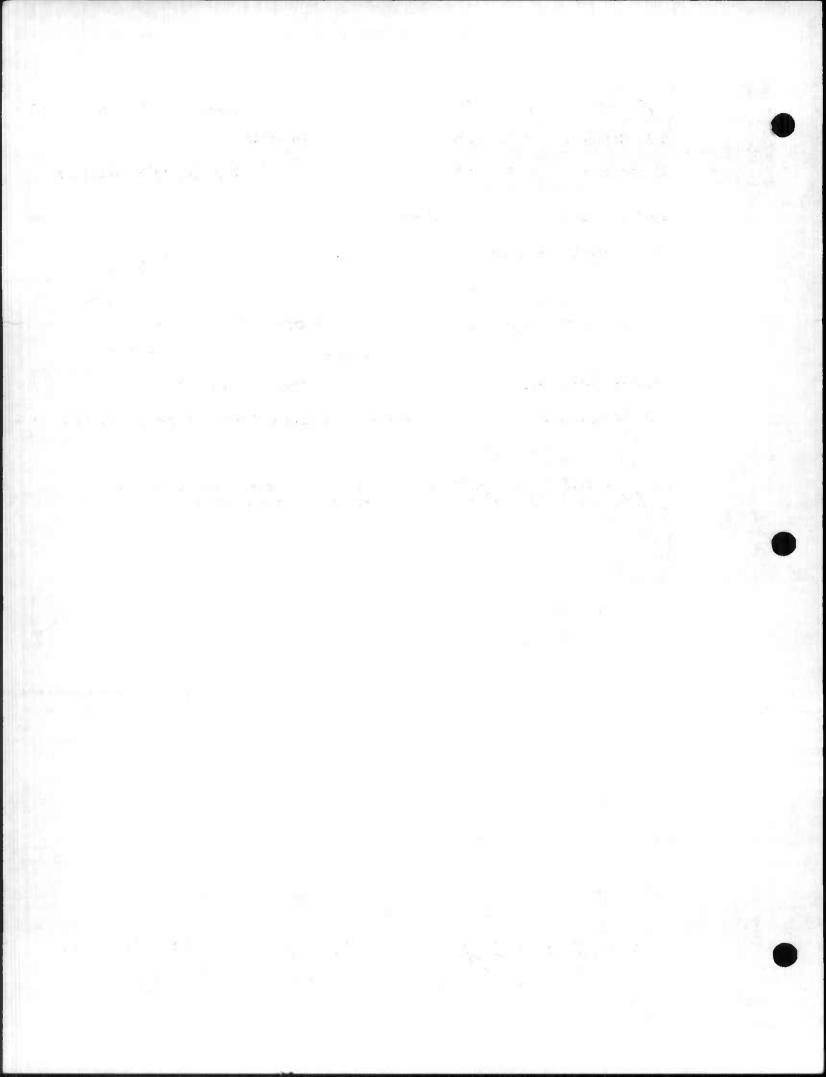
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State of Maryland / Department of Health and Mental Hygiene

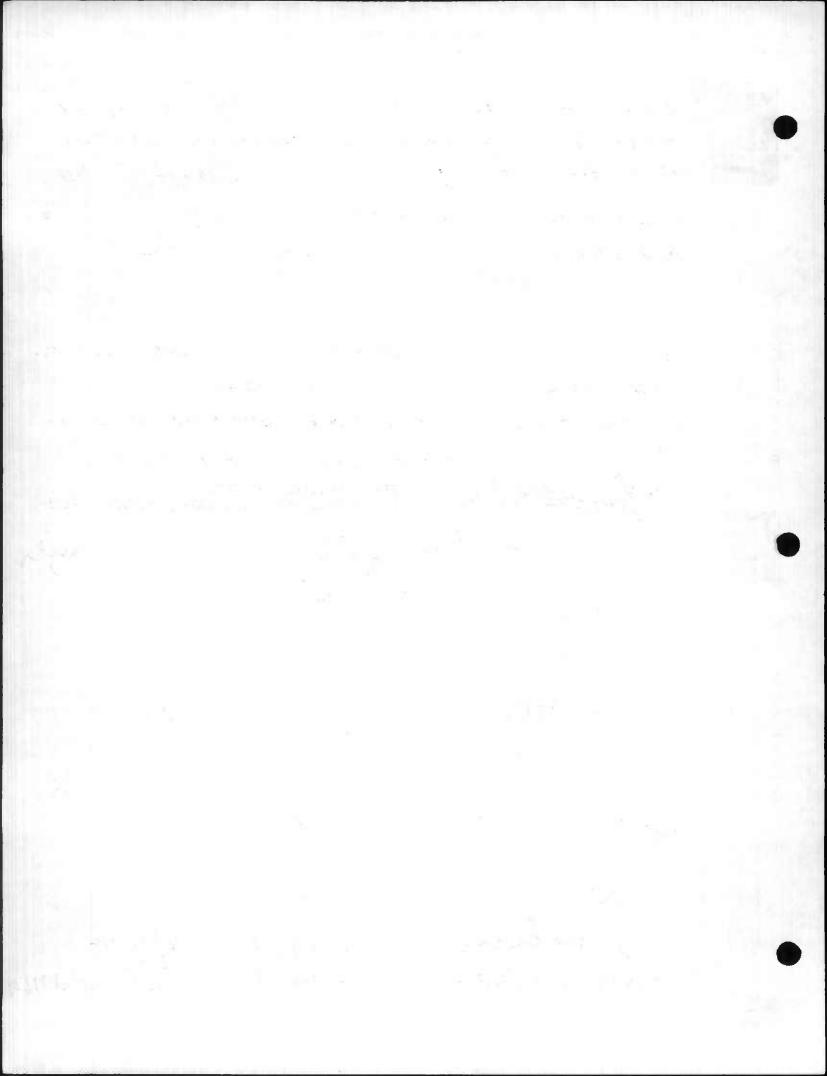
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Funeral Director		217 04 3003	ax □M 2√xF	7. Age (In yrs. 82	. last birthday) Yrs.	Months Months	Days	If Undar Houra	24 Hrs. Min.	8. Data of Bi (Month, D) July	th 87, Year) 31, 19	9. Bin Co Ma	hplace (Sountry) Lryla	itata o <i>r Foreig</i> n nd
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		19a. informant's Name/Ralationship ( David Brant/s								ourt, C				nd 2104
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		3 Suicida 8 Could not be datarmined	288 Place	of tnjury - At h	noma, farm, str	reet, factor	ry, office			28f. Location ( City or To	(Street and i wn, Stata)	Vumber or Ru	ral Route	Number,
within 24 hours effective to the European of the Completely filled in Medical Cert		29a. Certifier (Check only one)  (Check only one)	niner: On tha b	best of my kno asis of examina nar stated.	owledge, deetl ation and/or in	h occurred vastigation	at tha tir	na, data an pinlon, daa	d piace, th occurr	and due to tha ed at tha tima,	cause(s) ar data and p	nd mannar as aca, end dus	stated. to tha ca	use(s)
To the comp		29b. Signature and title of certifier				29	c. Licens	e number				signed (Mont	h, Day, Y	ear)
		lots & a	rdle	- fre		0	28	721			SEP	· 14+h	10	98
	3	30. Nama and address of person who	completed caus		m 23a) (Type, GER	Print)	Low	MBIA	7 1	on 2	-104	4.		
State Registrar	1	SFD 1 8 1000	32.	legistrar'a Sign										



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Daath 3. Time of Death **Physician** Month . CHADWICK ANNA W 2m 6 /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ONSU, CATOMSVIlle BAL 7 0 6. Sex If Undar 24 Hrs. 5. Social Security Number Birthplace (State or Foraign Country) **Funeral** Days 1 M 2 4 213-10-3414 Director Usual Residence of Decedent the Menylend 10a Stata 10h County 10c. City, Town or Location 10d. insida City Limits 7 is marked other than "natural", or flems 23s or 28s-f show traumstic event, the Medical Examinal must be notified at ELLICOTT CITY 1 ☐ Yes 2 No BALTIMORE Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21043 U.S.A. 515 OELLA AVENUE Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes ≥ 2 2No If Yes, Give Year or Dates: 11. Marltal Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Ricen, etc.) Race - American Indian Biack, Whita, atc. permit. Peges 1 and 2 should be filed within 72 hours after Department of Heelih end Mental Hygiene. Important: If Item 27 is merked other than "natural", or ites any Injury or other traumatic event, the Medical Experiment 1 ☐ Navar Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify þ WHITE 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EASTERN PRODUCTS CO. SUPERVISOR 12TH GRADE 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ERNESTINE HART FREDERICK STAPLES 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 515 OELLA AVENUE - ELLICOTT CITY, MARYLAND 21043 RUTH FERRELL (FRIEND) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremetion 3 □ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) 9/18/98 BALTIMORE PARKWOOD CEMETERY 21. Signature of Falleral Service Licens 22. Name and Address of Facility HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229 in the disease, or complications that ceuse i the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest Due to (or as a consequence of): P.O. Box 68760. Physiclan/Medical Due to (or as a consequence of) 98 ettending i ed by the e Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by d be detact 1 Yes 3 Probably 4 Unknown Records. þ been sig 24b. Were autopsy findings available prior to Completed 24e. Wes en eutopsy performad? completion of causa of death? pege 2 ete hes 1 Yas 2000 Division of Vital 25. Was case referred to medical Be 26 Place of Death (Check only one) examiner Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA this funeral 27. Manner of Deat 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending Naturel e Hospital or Attending £4 hours efter death. a Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital withth 24 hours e edical 29a. Certifier Certifying Phyeician: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) end manner as stated. Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and plece, end due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. Licanse number 29d. Date signed (Month, Day, Year) 1101 Maiden 31. Date filed (Month, Day, Year) SEP 1 32. Registrar's Signature 1 8 1998 State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Sel **Physician** 3:45 AM Margaret Rose Collins /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Hospital Baltimore N/A If Under 24 Hrs. If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 213-28-8981 1□M 2♥F 65 JAN 8, 1933 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Catonsville 1 ☐ Yes 2 No Directo 288-1 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Nema 23a or 149 Nunnery Lane Apt. Al 21228 USA 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Merried b 1 ☐ Yes 2 ☐XNo Specify: Specify 3 ☐ Widowed 4 ♥ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 1.2 College (1-4or 5+) Homemaker Domestic 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental int: If them 27 is marked o John Stark Edson Olive Leona McDade 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Barbara J. Edson/sister 514 Kent Avenue Catonsville, MD 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Good Shepherd Cemetery 9/21/98 Ellicott City, MD 21. Signeture of Funeral Service Licensee 22 Name and Address of Fecility
MacNabb Funeral Home, P.A. McDonald 301 Frederick Rd. Baltimore, MD 21228 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician vetire Pulmonary Disease /Medical Immediate Cause (Finel eau disease or condition resulting in deeth) Examiner Examiner physician and s the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that Initiated events resulting in deeth) Last Due to (or es e consequence of): Physician/Medical Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 | Yes 2 | No þ 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident actor: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. (Check only

MARGAMET Division of Vital Records, death. or A

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Baltimore, Maryland 21215-0020

State Registrar

29b. Signature end title of cartifier

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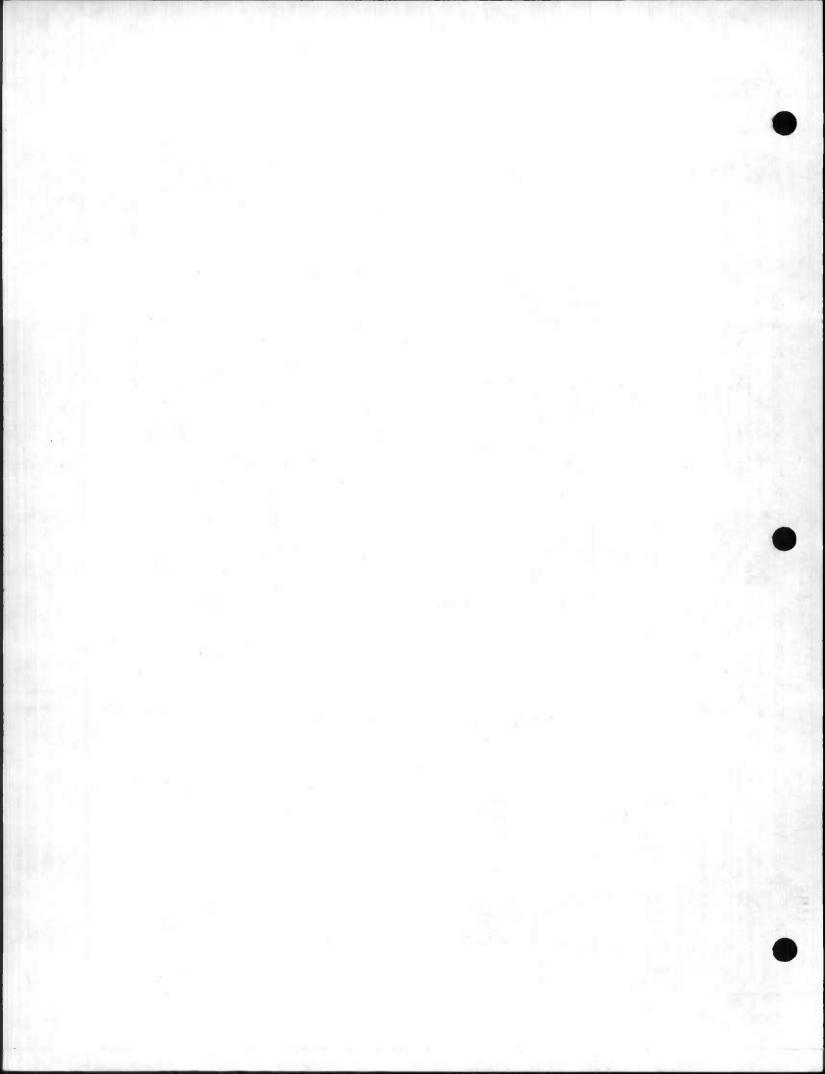
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

Mankouble, MD

AGNES ST

29d. Date signed (Month, Day, Year)



**Funeral** 

Director

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2 should be and Mental

Health reportant: If Item 27

**Physician** /Medical

Examiner

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Is marked

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death SEPTEMBER 17, 1998 **Physician** Mary Kathleen Carmody /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice @ Mercy Baltimore N/A | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth | Months | Days | Hours | Min. | AUG 24, 1958 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (Steta or Foraign 1□ M 2□√F Maryland 215-78-9074 40 Usual Rasidence of Decedent 10a. Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Director N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21202 USA 928 N. Calvert St., Apt. 2 - B12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indien, Black, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yas 2 ☐ No If Yas, Give X 1 ☐ Yes 2 No White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Sollege (1-4or 5+) Elementary/Secondary (0-12) Chef Restaurant 18. Mother's Nama (First, Middle, Maiden Surnama) 17. Father's Nama (First, Middla, Last) Be Mary Virginia Lewis James Keenan Carmody 19a. Informant's Neme/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Mary L. Carmody / Mother 1139 Tyler Avenue Annapolis, MD 21403 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 24 Cramation 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory, Inc. 9/17/98 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Addrass of Facility C )on alo Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 Dawn McDonald 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death Immediata Cause (Finel disaase or condition rasulting in death) Examiner Sequentially list conditions, if any, laading to immediate cause. Entar Undarlying Causa (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Physiclan/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Driknown by 24b. Were eutopsy findings available prior to complation of cause of death? Completed 24a. Was an eutopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examinar? 26. Place of Deeth (Check only one TELLA MARIS AT MERCY To. Other: 4 Nursing Home 5 Rasidance 6 Othar (Specify) HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No 27. Menner Death 28d. Dascribe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yas 2 No 3 Suicide 6 Could not be 28a. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Medical 29a. Certifier 10 Certifying Physician: To the best of my knowledge, death occurred et the tima, data and place, and dua to the causa(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signad (Month, Day, Year) ath (Item 23a) (Type, Print)

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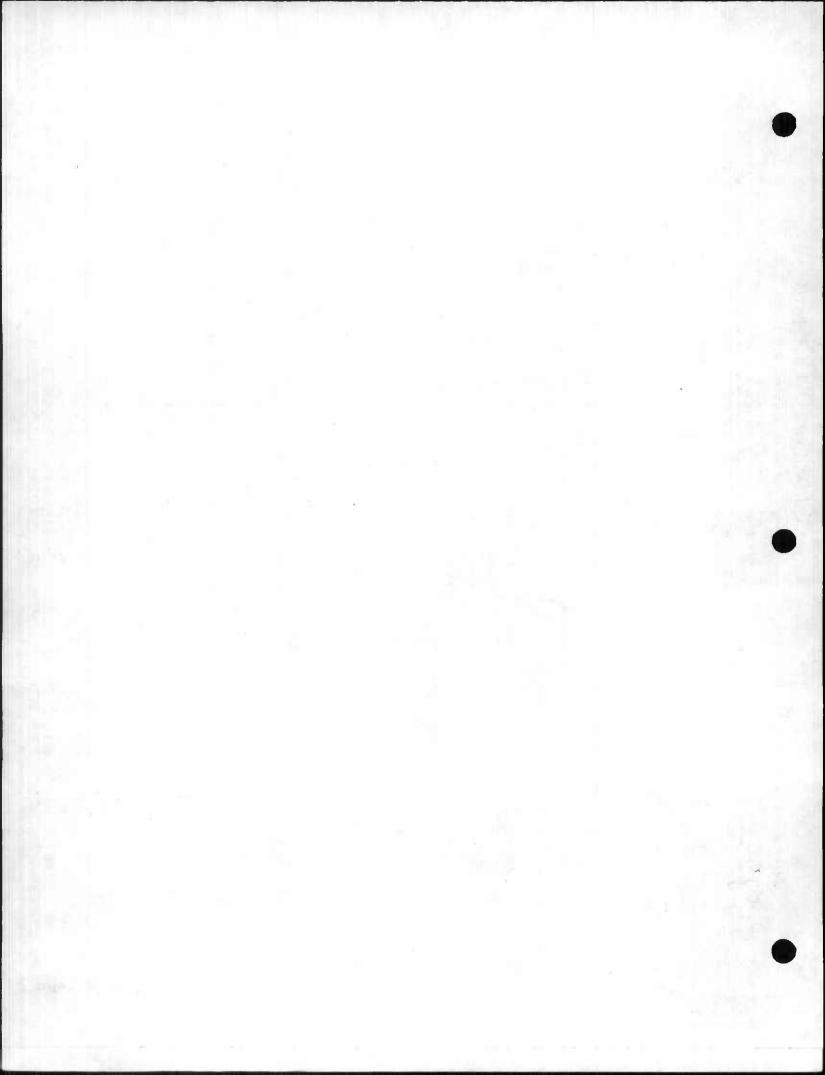
after death Director:

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Registrar

3. Registrer's Signature

PAUL PLACE BALTIMORE 21202

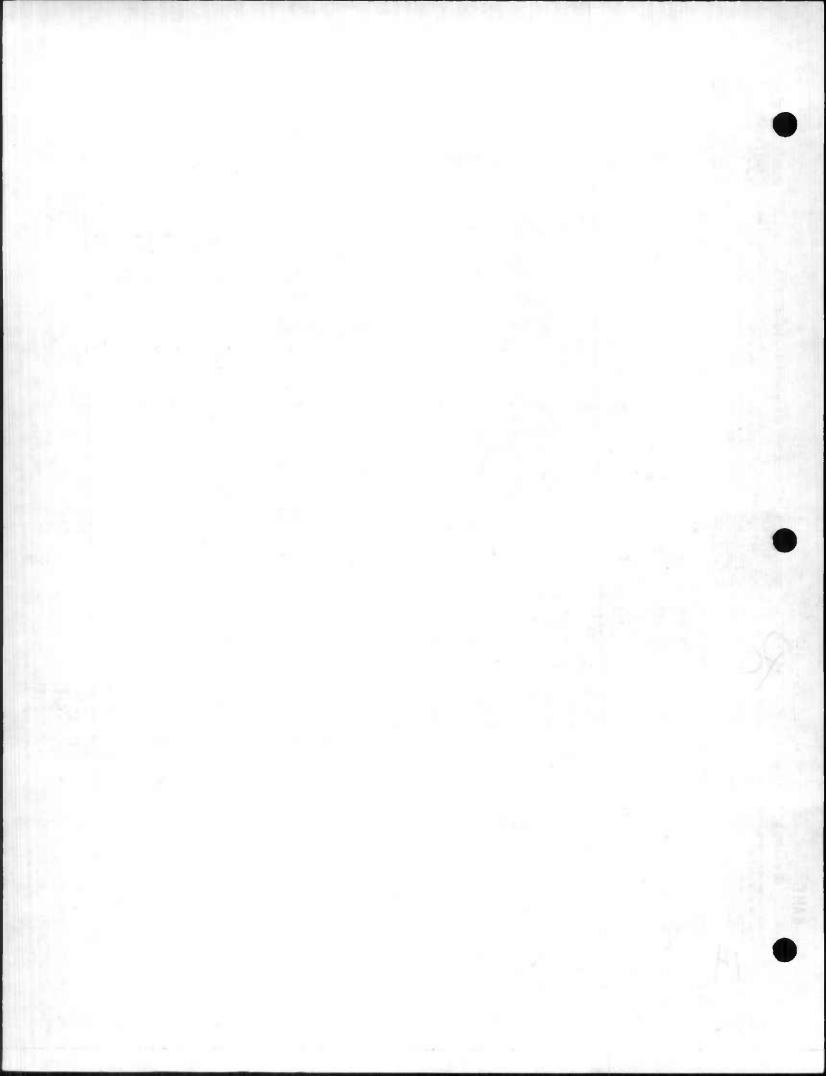


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician FRANCES DELORES CULLUM SEPTEMBER 2305 15 1998 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a ST AGNES HEALTH CARD BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb. 02 1928 9. Birthplace (State or Foreign **Funeral** Days Months Hours 215-42-7309 1 M 2 XF 70 Maryland Director **Usual Residence of Decedent** with the Maryland 10e State 10b. County 10c. City, Town or Location 10d Inside City Limits ahow Md. 1 ☐ Yes 2 No Director **Baltimore** Baltimore County 'natural', or hams 23s or 25s-f 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? TISA 21227 2602 Gehb Ave. deeth Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? i Hygiens. Other than "natural", or herr 1 Never Married 2√7 Married 1 Yes 2 No If Yes, Give Year or Dates: altimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) House wife Home Owner permit. Pages 1 and 2 ahouid be filed. Department of Health and Membi Hyg. Important: If New 27 is merked other any Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Battaglia Glorioso Vincent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2602 Gehb Ave. Baltimore, Md. 21227 (Husband) Eugene C. Cullum 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Sept.19 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Memorial Park Glen Burnie, Md. 4 ☐ Donation 5 ☐ Other (Specify) 1998 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
McCully-Polyniak Funeral Home 237 E. Patapsco Ave. Baltimore, Md. 21225 23a. Part1. Enter the disease, or complications that caysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) KESPIRATORY FAILURE 10 days Examiner Due to (or as a consequence of): SEPSIS 10 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ď 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy parlomed? 1 Yes 20 No 1 ☐ Yes 2 No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Malinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No to ä 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Affiar Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident or Attend after death Director: 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

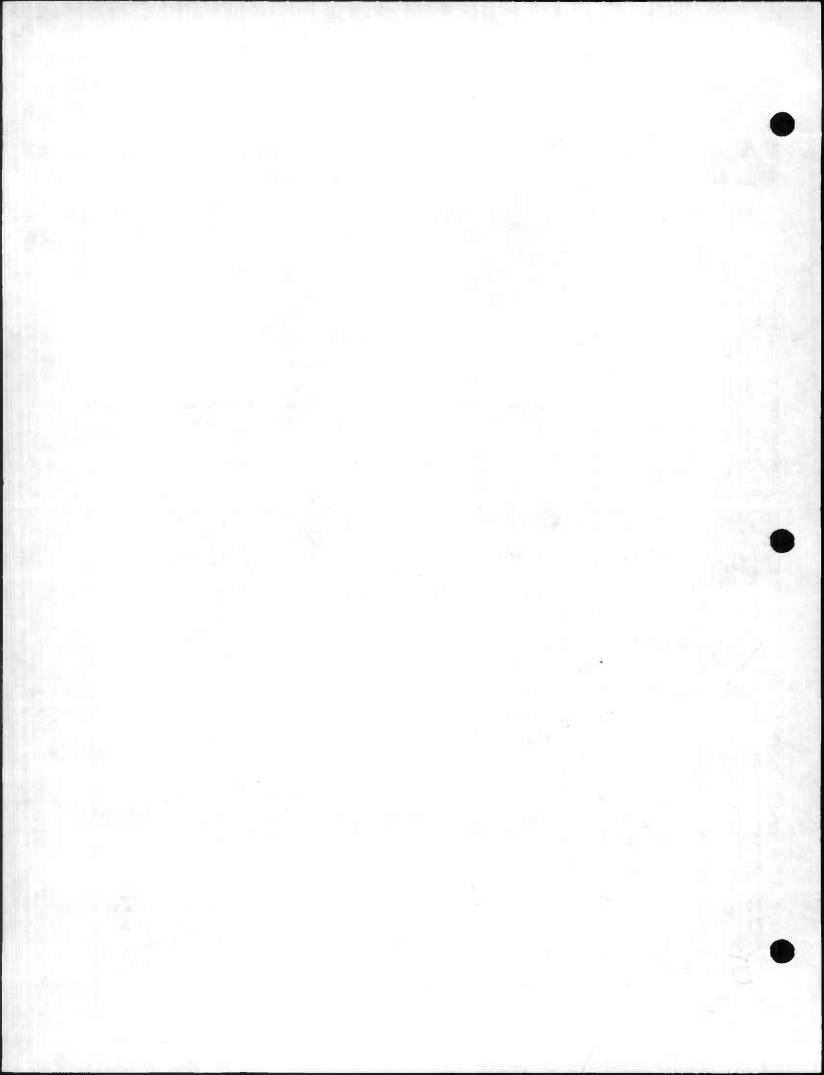
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier edical To the Hosp within 24 ho To the Fund completely f 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10879 September 16 1998 MIN Hermone 0.8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 MD 21229. Battimere Caton AVE 31. Date filed (Month, Day, Year) SEP 1 8 1998 32. Registrar's Signature State Registrar

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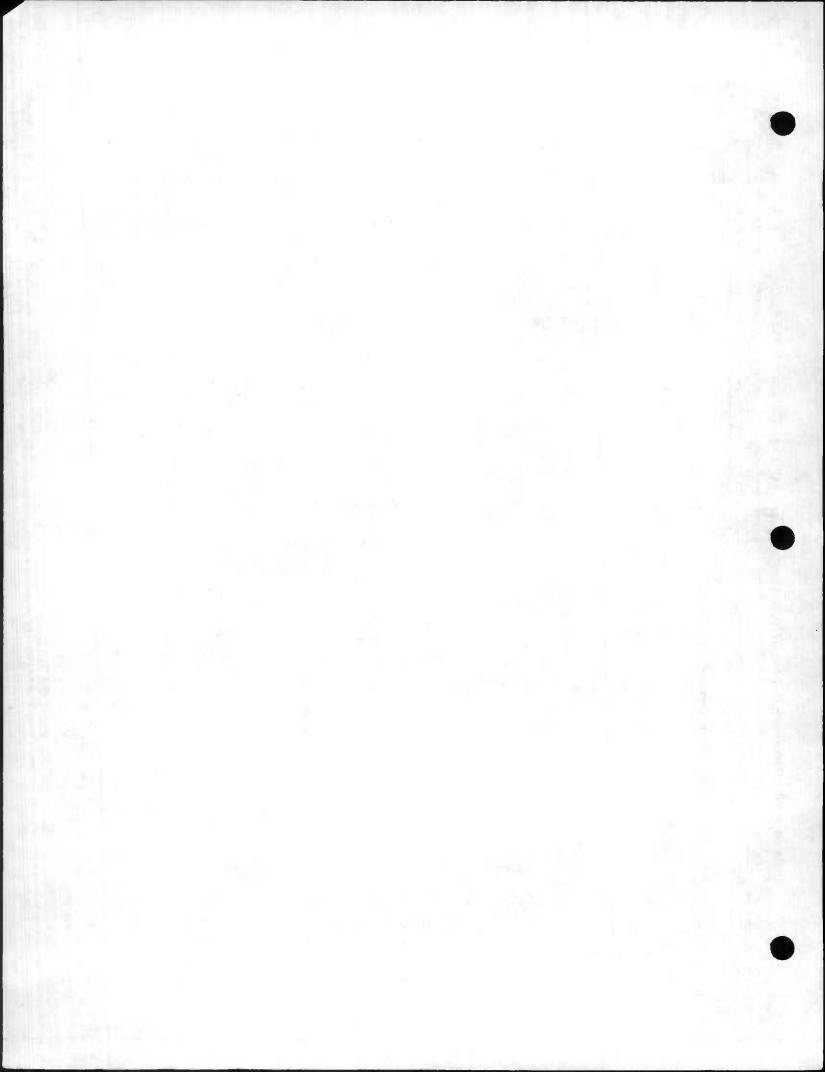
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Physician (Madical	that y thi gillia of hiora - ham -	2. Date of De Month G	Day Yeer	3:00 A.M.	
/Medical Examiner	4a Facility Name (If not institution, give street end number) 4b. City, To	own, or Location of Death			
Funeral Director		24 Hrs. 8. Date of Bir		o (State or Foreign	
with the Maryland a or 28a-f show be notified at	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Md N/A Baltimore		10d.	Inside City Limits	
	1 1911 Latitiway Avenue		10g. Citizen of What Country	?	
her dea herra mer m	11. Marital Status  12. Wes Decedent Ever in U.S. Armed Forces?  1 Never Merried 20 Merried  3 Widowed 4 Divorced  12. Wes Decedent Ever in U.S. Armed Forces?  1 Yes, Sine 1 Yes, Sine 1 Yes, Sine 1 Yes, Give 1 Yes or Detes:				
21215-0020 ed within 72 hours at splans. The Medical Exem Completed by I	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondary (0-12) 6th grade  16a. Decedent's Usuel Occupation (Give kind of work done during mos	st of working	16b. Kind of Business/Indust		
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Mary nd 2 sho sith and 27 is me	19a. Informant's Neme/Reletionship (Type, Print)  John Crawford - Husband  19b. Meiling Address (Street end Number 3915 Calloway Aver		er, City or Town, State, Zip Co lone, Md 21215	rde)	
Fages 1 a hant of Hear rit: If Nem.	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town,		
Baltin pamit. Pa Department Important any injury ands	4 Donation 5 Other (Specify) Woodlawn Cemetery  21. Signature of Funeral Service Exercee 22. Name and Address of Facility  March F. H.		Baltimore, Mo 300 Wabash A		
/Medical Examiner programming for the programm	fmmediate Cause (Finet disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initieled events resulting in death) Last  Due to (or es e consequence of):	Lyfart. Disease	low N	l'intes Cears	
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within within comp	29b. Signature and late of continue 29c. License number D 226	45	29d. Dete signed (Mohith, Da)	y, Year)	
State	24 State Stad March Day Very	AVE. BA	ecto. Ms. 2	1222	
Registrar	OFF A CARROL & PROMATER MY				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Yaar **Physician** WILLIAM CRONIN SEPT. 15, 1998 Gordon 3:40 P.M. /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNAPOLIS ANNE ARUNDEL COLONIAL MANOR ASSISTED LIVING CENTER If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours XXM 2□ F Months Director 9/27/26 214-22-9180 Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or heme 23s or 28s-f ahow the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2√ No Director Baltimore Loch Rayen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8338 Kendale Road 21234 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, atc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: WWII Specify P 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien, Important: if item 27 is marked other that any injury or other treumatic evant. Item. Engineer Telephone 6 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 2 CYRIL CRONIN MARY SMITH 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY HOLLENBAUGH SISTER 1 SHAMROCK CIRCLE WESTMINSTER MD 21157
200. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 ☐ Other (Specify) NEW CATHEDRAL CEM. 9/19/98 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JOHNSON FUNERAL HOME, P.A. 23s Farti. Enter the disease, or complete tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, buck, or heart failure. List only one cause on each line. TOWSON, MD Approximate triterval Between Onset end Death **Physician** /Medical Larcinoma Immediata Cause (Final Month disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): kin Sonisu Box 68760, Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacpo use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown abehen Records, þ 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 43815 752 1□ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. tnjury at Work? After 1 Natural 5 Pending death. To the Hospital or Attendit within 24 hours after death.
To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner es stated.

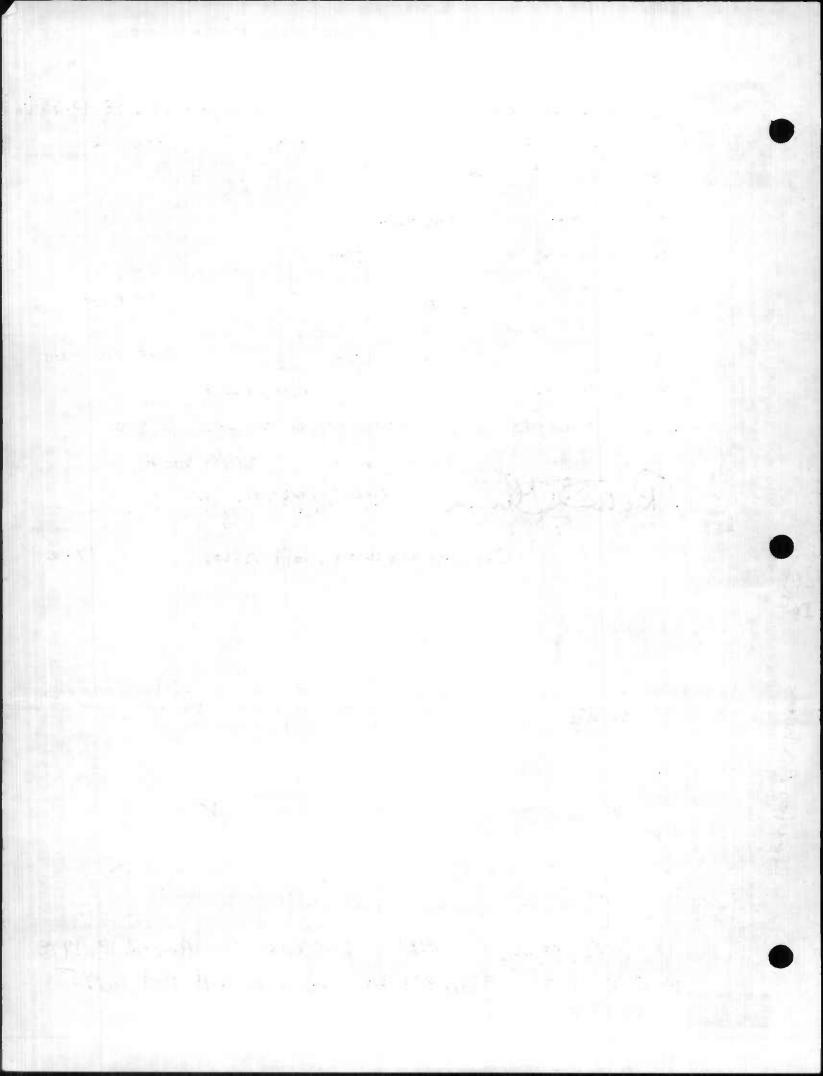
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29c. License number 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) D14136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Of Crain Towers Glen Burnie DALDITS. SAWHNEYMD Swife 201 Crain Towers Glen Burnie md 21061, 31. Date filed (Month, Day, Year) 32, Registrar's Signature State 1 8 1998 Registrar

**DHMH 16 Rev 6/95** 



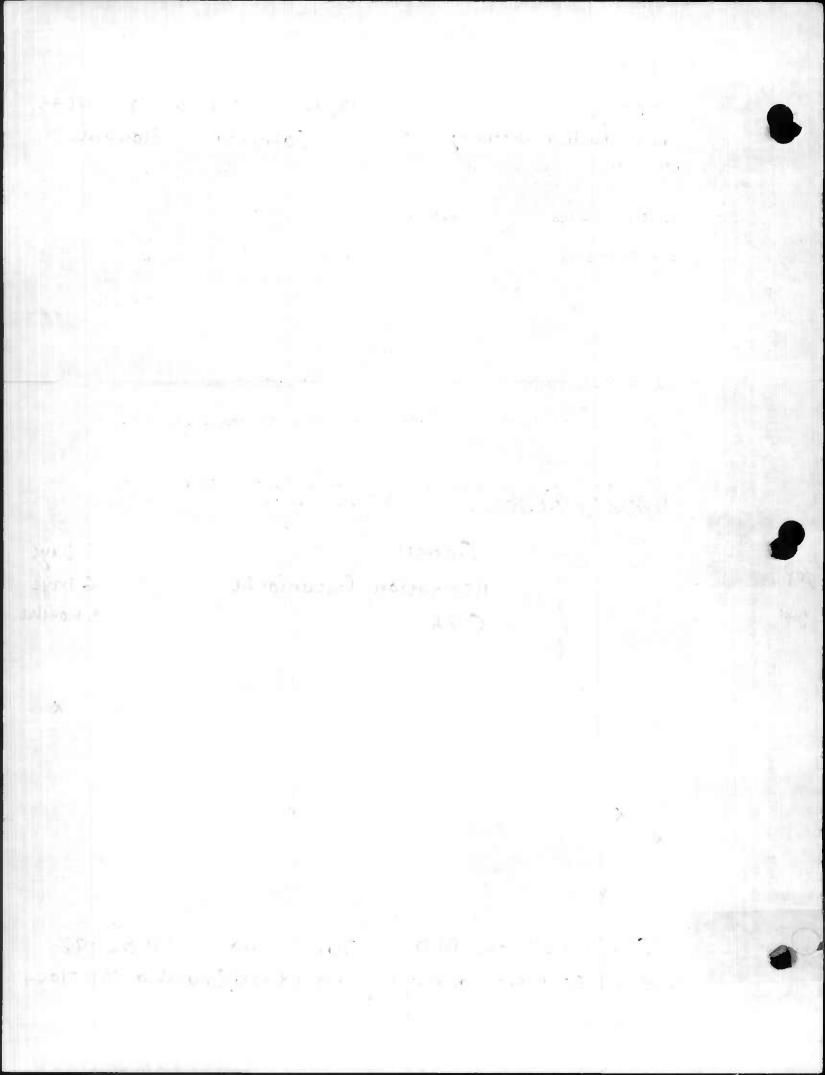
# Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

James William Crawford   James William   James Wi									Cer	tifica	te of	Death		R	eg. No.	2 (	3010
James Nill Liam Crasford   James   J	veician	_	. Decedent's Nan	ne (First, Midd	dle, Last	)								Month a			3. Time of Death
2.18—16—4.289 2.18—16—4.289 2.18—16—4.289 2.18—10—4.28 2.18—16—4.289 2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2.18—10—2	Medical aminer	-									T.	4b. City, Tow	m, or Locati	in of Deeth	4c. Cou		10:554
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Too. State   10c. County   10c. City Town or Location   10d. Tok Code   176.06 Crest Drive	eral ctor		218-16-4	1289				(In yrs. lasi					Min.	(Month, Day,	Year)		plece (State or Foreigntry)
11 Martet Status   14 Martet Status   14 Martet Status   14 Martet Status   14 Martet Married 20 Married   16 Married Married 20 Married   16 Married Married 20 Married   16 Married Married 10 Married Mar	ed:	-		1	у		1	IOc. City, T	own or Lo	cation							10d. Inside City Limit
11   March Status   12   March Status   12   March Decoder   Ever in U.S.   13   March Decoder   Chipperic Chipper	į		MD	Washi	ngt	on		Hager	stow	1							1□Yes 2□N
1. Marine Status   1. Marine S	lrec	1	Oe. Street and Nu							1	ip Code			1	0g. Citizen	of What Cou	ntry?
The companies of the	ai		17606	Crest I	riv	e				21	740						
19a. Informant's Name/Facilitationship (Type, Print)   19b. Nating, Address (Street and Number or Rural Route Numbers, City or Town, State, 25 Code)   17606 Crest Drive Hagerstown, MD 21740   20b. Date   20b. Place of Disposition   18 durial 2   20c location of 3   Removal from State   20b. Place of Disposition   18 durial 2   20c location of 19 during of 18 dur	by		1 Never Men			Armed For 1 XYes If Yes, Gi	orces? 2 ☐ No ive						in? (Specify Puerto Rici	Yes or No- an, etc.)	6	Black, White	etc.
Gloria H. Card Spouse  20a. Method of Disposition  1 Reurial 2 Cicemation 3   Removal from State  20b. Method of Disposition  1 Reurial 2 Cicemation 3   Removal from State  20b. Place of Disposition  1 Reurial 2 Cicemation 3   Removal from State  20b. Place of Disposition  1 Reurial 2 Cicemation 3   Removal from State  20b. Place of Disposition  1 Reurial 2 Cicemation 3   Removal from State  20b. Place of Disposition  1 Reurial 2 Cicemation 3   Removal from State  20b. Place of Disposition  1 Reurial 2 Cicemation 3   Removal from State  20b. Place of Disposition  21. Removal from Republic Place  22b. Place of Disposition  22c. Name and Address of Reality  22c. Name and Address	ted		(Spe					1	6e. Deced	ient's Usi	ual Occup	ation	of wadding		16b. Kind of	f Business/Ir	ndustry
198_Informart's NameArelationship (Type, Print)   190_Nalling Address (Siree and Number or Rural Route Number, City or Town, State, Zir Code)	npie				Ť				life. I	life. DO NOT use retired)			or working				
198_ Informant's Name Relationship (Type, Print)   190_ Maling Address (Siree and Number or Rural Route Number, City or Town, State, Zir Code)   17606 Crest Drive Hagerstown, 200_ Date   200_ Date of Disposition   198_ Burial 2 Cicemation 3   Removal from State   200_ Place of Disposition   198_ Burial 2 Cicemation 3   Removal from State   200_ Place of Date of Date of Date of Print   200_ Part   Enter the disease, are with a Cicemation 3   Removal from State   200_ Part   Enter the disease, are with a Cicemation 3   Removal from State   200_ Part   Enter the disease, are with a Cicemation   200_ Part   Enter the disease, are with a Cicematic   200_ Part   Enter the disease, are with a Cicematic   200_ Part   Enter the disease, are with a Cicematic   200_ Part   Enter the disease on each line.   200_ Part   200_ Pa	Co		12		1 0			I	nspe	ctor		40.14-11-1	1. No				ufacture
198_Informarks Name-Relationship (Type, Print)   199_Maling Address (Street and Number or Rural Route Number, City or Town, State, Zie Code)	Be	1													vraiden Sum	rame)	
Gloria H. Crawford/Spouse  20a. Method of Disposition  1	Jo				-				405 14 11		(0)				City on To	- Ctata 7	n Codel
20c. Method of Disposition 1								201									
Part   Other elgorificant conditions contributing to death but not resulting in the underlying cause given in Part			GIOria H. Crawford/Spouse 1/606 Crest Drive Hagerstown, MD 21740  20a. Method of Disposition (Name of Disposition										own, State				
The stream of th		1	1 🕅 Burial 2	☐ Cremation			State							/			
Grove Funeral Home, P.A.  23a. Part. Enter the disease, exempt Stilons that caused the death. Do not enter the mode of Ward, societate and Better Stock, or heart failure. Let only be cause on each line.  Immediate Cause (Final Immediate Cause (Final Person of Part II)  Sequentially list conditions, and the stiling in death)  Due to (or as a consequence of):  24b. Did tobsecto use contribute to the cause of a still report of the cause of		-3	4 Donation 5 Other (Specify) Fairview Cemetery 6/18/98 Artemas, PA										s, PA				
23a. Part I. Entar the disease, an exhibition of the shock, or heart failure. Use a cause on each line.    The shock of heart failure. Use and place and place.	Important: I any injury o pnce.		61)	1	57	TO								DΛ			
Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):    Due to (or as a consequence of):		+	220 Part Enter	31. Over Full Elai Dollie, F.A.  3a. Part Enter the disease, Francisco and Elain Space of May secret Cardia and Space of Constant Space of													
Immadiate Cause (Final disease or condition resulting in death)   Due to (or as a consequence of):   Due to (or as a consequence of):     Due to (or as a consequence of):     Due to (or as a consequence of):	п		shock, or her	art failure. Li	Lonly o	cause on	eech line		DO HOT OH	or and me	do or dyn	ig, obort do o	, di di di di 10	, , , , , , , , , , , , , , , , , , , ,			Interval Between Onset and Death
Due to (or as a consequence of):    Due to (or as a consequence of):	_	1	Immediate Cause	(Final		0				1.		101	1 - ~	1 .			14
Sequentially list conditions, if any, leading to immediate any leading in death) Last and local performance of the cause of the caus	r	1	disease or conditi resulting in death)	ulting in death)									IIVNO				
Cause (Disease or injury intributed events resulting in deeth) Last  Due to (or as a consequence of):  Due t	je 🔳							ue to (or a:	s a consec	luence or	,.					1	
Cause (Disease or injury thin initiated events resulting in deeth) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):    Cause (Diseases or injury thin initiated events resulting in deeth) Last    Cause (Diseases or injury thin initiated events or injury to the cause of death of the death of the cause of death of the cause of death of the deat	amir.		Sequentially list or	onditions	-	b	D	ue to (or es	s a consec	uenca of	):					1	
That initiated events are sulting in deeth) Last and initiated events are sulting in deeth) Last and place, and due to the cause of the			if any, leading to it cause. Enter Und	mmediate lerlylng												i	
Part II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other elgnificant conditions contribute to the cause of completion of cause of cause of cause of completion of cause o	Ca		nat initiated events  Due to (or as a consequence of):														
24a. Was an autopsy performed?  24b. Were autopsy find available prior to completion of cau of death?  1   Yes 2   No	900				U.												
24a. Was an autopsy performed?  24b. Were autopsy find available prior to completion of cau of death?  1   Yes   2   No	lan/					0											
24a. Was an autopsy performed?  24b. Were autopsy find available prior to completion of cau of death?  1   Yes   2   No	ysic	P	Part II. Other signi	ificant condit	lone co	ntributing to d	eath but	not resultir	ng in the u	nderlying	cause gh	en in Part I.		23b. Dld to	bacco uae	contribute	to the cause of deat
24a. Was an autopsy performed?    24a. Was an autopsy performed?   24b. Were autopsy finch available prior to completion of cau of death?   1   Yes   2   No   No   No   No   No   No   No	4		N	ONE										1 2 Y	es 2 N	o 3□Pro	obably 4 Unkno
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death 1 Natural Solicide 3 Suicide 4 Homloide  28a. Date of Injury (Month, Day Year)  28b. Time of Injury M 28c. Injury et Work? 1 Yes 2 No  28c. Injury et Work? 1 Yes 2 No  28d. Describe how Injury occurred  28d. Describe how Injury oc	dby	-												24a Was a	in autonsv	24b. V	Vere autopsy finding
25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Pacific Residence 6 Other (Specify)  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homloide  28a. Date of Injury (Month, Day Year)  28b. Time of Injury M 28c. Injury et Work? 1 Yes 2 No  28c. Injury et Work? 1 Yes 2 No  28c. Injury et Work? 1 Yes 2 No  28c. Location (Street and Number or Rural Route Number or Rural Rou	ete									44				perfor	med?	a	vailable prior to ompletion of cause
25. Was case referred to medical examiner?  Hospital:   Impatient   2   ER/Outpatient   3   DOA   Dote   4   Nursing Home   5   ER/Seldenca   6   Other (Specify)    27. Manner of Death   1   Natural   2   Accident   3   Suicide   4   Homloide   4   Homloide   4   Homloide   28e. Place of Injury   28b. Time of Injury   M   28c. Injury et Work?   1   Yes   2   No   28c. Place of Death   City or Town, State)    29e. Certifier   Check only one)   29e. Certifier   Check only one)   29e. Certifier   29e. Certifier   29e. Certifier   29e. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   29e. Dote   29e. Dote   29e. Dote   29e. Dote   29e. Certifier   29e. Signature and title of cartifier   29e. License number   29e. Date signed (Month, Dey, Year)   29e. Dote   29e. Dote   29e. Date signed (Month, Dey, Year)   29e. License number   29e. Date signed (Month, Dey, Year)   29e. Dote   29e. Date signed (Month, Dey, Year)   29e. Date signed (Month, Dey, Year)	dm														1		
1   Yes   2  No																0 1	LI Yes 2LI NO
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homlcide  28e. Placa of Injury - At home, farm, street, factory, office  29e. Certifier (Check only one)  29b. Signature and title of cartifier  29b. Signature and title of cartifier  29c. License number  28c. Injury et Work? 1 Yes 2 No  28c. Injury et Work? 1 Yes 2 No  28c. Injury et Work? 1 Yes 2 No  28d. Describe how Injury occurred  28d. Desc			examiner?		-	Hospital:		-0			Ott	2011		1		0	24.4
29b. Signature and title of cartifier  29b. Signature and title of cartifier  29c. License number  29c. License number  29c. License number  29c. License number  29d. Date signed (Month, Dey, Year)  29d. Date signed (Month, Dey, Year)	-	-															ily)
29b. Signature and title of cartifier  29c. License number  29d. Date signed (Month, Dey, Year)  29d. Date signed (Month, Dey, Year)  August 18, 1998	tion		1 Natural	5 Pendi	ing tigation	(Mor	nth, Day	Year)					No				
29b. Signature and title of cartifier  Doo 936  29c. License number 29d. Date elgned (Month, Dey, Year)  Doo 936  August 18, 1998	ertifica		3 Suicide	6 ☐ Could	not be	28e. Placa of Injury - At home, farm, street, factory, office 28f. Locat											
29b. Signature and title of cartifier  29c. License number 29d. Date signed (Month, Dey, Year)  August 18, 1998	dicai	2	(Check only	1 Certifyi 2 Medica	ing Phy I Exami	ner: On the b	pasis of e	xamination	dge, death and/or in	occurre vestigatio	d at the ti	me, date and opinion, deatt	place, and h occurred	due to the cat the time, d	ause(s) and late and plac	l manner as ce, and due	stated. to the cause(s)
	M		29b. Signature and	d title of cartifi	ier		0			2	9c. Licens	se number		2	9d. Date sig	gned (Month	, Dey, Year)
			IN	Win	1/20	alan)	+	M	0		DO	>9.70	6	1	Tuan	st 18	3 1998
M. E. Byrkit 3 Byrkit Dr Williamsnort Md 21795		3	30. Name and add	lress of person	n who c	ompleted cau	se of dea	ith (Item 23	3a) (Type.						1	5 10	1110
		1	M. F.	BYCK	it	- 1	3 3	vrK	24	Dr	L	Dilli	à Ma	noint	Ma	21=	195
	trar		200	1013	30	1 miles		1		no	1.1						



Physician	#24a per Phy G763 9/1  1. Decedent's Name (First, Middle, I	Last)		Ciac	140	2. Dete	Reg. A	Day C	Year	3. Time of Death 2045
/Medical Examiner	4a Facility Name (If no institution, o	RICHARD vive street and number al Specialt	y Unit	,	4b. City, Town,	1	f Deeth	c. County		1
Funeral Director			(In yrs. lest birthe	day) If Under 1 Ye	ar If Under 24		of Birth hith, Dey, Yee Ly 26,	, , , ,		ece (Stete or Foreign try)
Marylend Fed at	Usuel Residence of Decedent  10a. State  10b. County  Maryland Howard		10c. City, Town o							0d. Inside City Limits 1 ☐ Yes 2 ☐ No
wher death with the Maryler ritems 23s or 28s-f show riner must be notified at Funeral Director	10e. Street end Number 6334 Cedar Lane			10f. Zip Code 2104				Citizen of V	Vhat Count	try?
urs effer des	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Wes Decedent Ev Armed Forces? 1 🖾 Yes 2 🗆 No If Yes, Give Year or Dates: 1.0		13. Was Decedent of If Yes, specify C		? (Specify Yes uerto Rican, e	s or No- itc.)	or No- lc.)  14. Race - American Indien Bleck, White, etc.  Specify: White		
filed within 72 ho Hygiene. sther than "naturn ent, to Medical	15. Decedent's (Specify only highest of Elementary/Secondary (0-12) 1.2	Education grade completed) College (1-4or 5+	16a. D	ecedent's Usuel Occ Give kind of work do fe. DO NOT use ret Budget O		working		Kind of Bu		
and Mental Hygi e marked other e marked other sumatic event, To Be Co	17. Father's Neme (First, Middle, La William Henry Cl					Name (First, beth Mo			Θ)	
os 1 end 2 of Health a item 27 is other tra	19a. Informant's Name/Reletionship Anne Fleming/da  20a. Method of Disposition 1  Burial 2  Cremation 3	ughter	620 20b. Plece of D	Meiling Address (Street)  1 Ironwo ( Disposition (Name of crematory or other p	od Way, Co		,Mary		21045	
permit. Page Department of important: if any injury or pnce.	4 Donation 5 □ Other (Spe 21. Signature of Fundral Service Light Ronal I	onsee Wade, Dir		22 Name end Ad State Ar Baltimor	e, Mary	land 21	1201	Balt	imore	Street
Physician /Medical Examiner	shock, or heart failure. List on Immediate Ceuse (Final disease or condition resulting in death)	5	iebsi	S			atory arrest,			Approximate Interval Between Onset and Death  2 Days
je literal		AS	oue to (or as a co	nsequence of)	lcumo	uia			1	6 Days
ing physician and as as the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last	c. C	V A							5 Months
the the daeth certified of the attanding plateched for use as the datached for use as the psycian/Mec	Part II. Other significant conditions	contributing to death but	not resulting in t	he underlying ceuse	given In Part I.	23	b. Did tobac		ntribute to	the cause of death
been sign should be						24:	a. Wes en eu performed	itopsy	ava cor	ere eutopsy findings ailable prior to mpletion of cause death?
clen: The law entificate has setor, page 2 a Be Comp	25. Was case referred to medical examiner?				26. Place of	Death (Chec		2 🖄 No	1 🗆	Yes 2□ No
After this co funeral dire	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	28a. Date of Injury (Month, Dey	t 2 ER/Outp (Year) 28b. Tin	ne of 28c. In	Other: 4 Nursi		Residence			γ)
To the Hospital or Attending P within 24 hours efter death. To the Funeral Director: Affart completely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could not determine	building, etc.	(Specify)	n, street, factory, offi		City	or Town, St	ate)		Il Route Number,
To the Hospital within 24 hours e To the Funeral I completely filled Medical Ce	(Check only 2 Medical Ex	Physician: To the best of aminer; On the basis of e end manner state	examination and/	or investigation, in m	y opinion, deeth	plece, and due occurred at th	e time, date o	end place,	and due to	the ceuse(s)
Twit on V	29b. Signeture and title of certifier.  Socyoty  30. Name and address of person where the second sec	. Shoh,	MD ath (Item 23a) (To	Do	c) 52		56		02	98
State		H, UD (C	% CS HI	chang Ric		+210,0	olum	ubia	, M	D 21044

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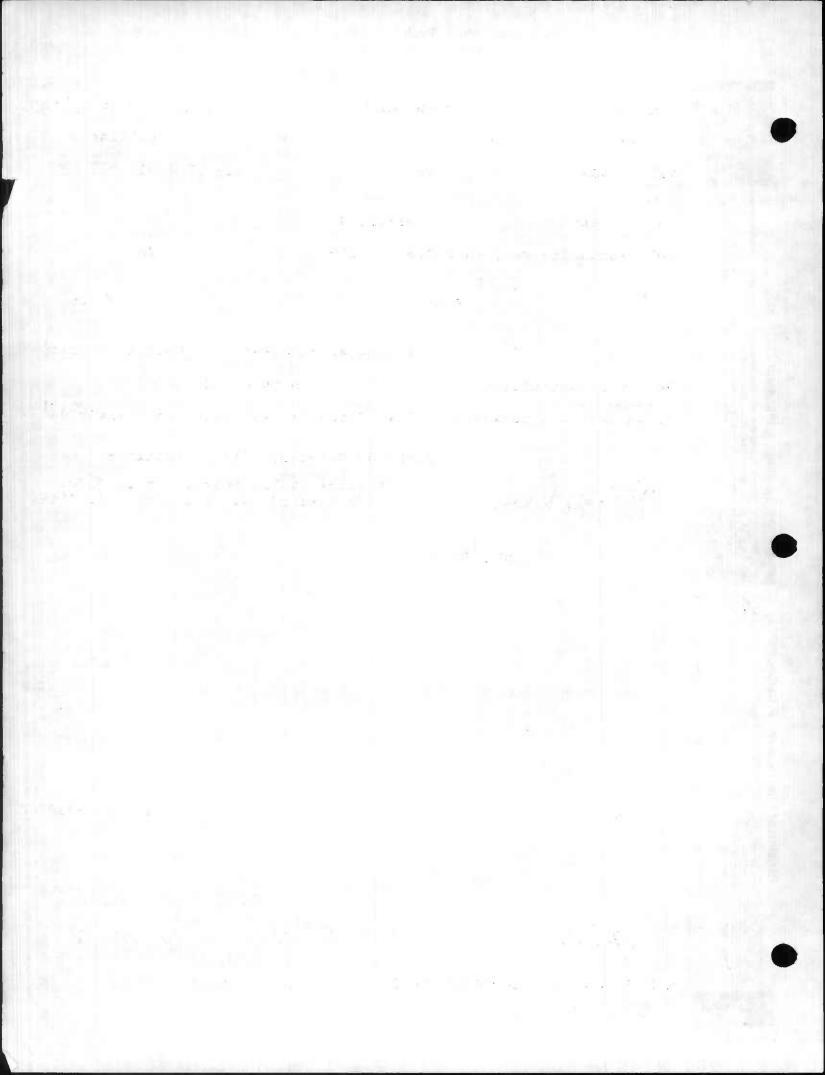


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month **Physician** September 16 1998 CHRONISTER MICHAEL /Medical 4b. City, Town, or Location of Death 4a Facility Name (ff not institution, give street and number) 4c. County of Death Examiner Baltimore Stella Maris Hospice Timonium | H Under 1 Year | H Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | Aug 21 1951 9. Birthplaca (State or Foreign Country)
Pa. 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1⊠ M 2□ F 4 7 Yrs. Director 213-60-4864 Usual Rasidance of Dacadent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is merked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Expressional Province invalid 10a Stata 10h County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Director Harford Belair, Md. Md 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21014 USA 201 Yorkshire Way, Unit One Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 ⊠Yas 2 No If Yas, Giva Year or Datas: Viet. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: À White 3 Widowed 4 Divorcad Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade complated) Elemantery/Secondary (0-12) College (1-4or 5+) Programer Annalyst Social Security 12 th 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) E. Sadofsky Donald B. Chronister Dorothy 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 1014 19a. Informant's Name/Ralationship (Type, Print) 201 Yorkshire Way Unit One, Belair Susan Lavena Chronister 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 1 Burial 2 □ Cramation 3 □ Removal from State Parkwood Cemetery 9/19 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatule of Funaral Sarvice Licensee 22. Nama and Addrass of Facility
Hartley Miller Funeral Home, CHTD. Hiller 21234 7527 Harford Rd. Baltimore, Md. 23a. Part1 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Oligodendroma **Examiner** Dua to (or as a consaquanca of): Examiner The law requiras that the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Causa (Disease or Injury that initiated avants rasulting in death) Last Dua to (or as a consaquance of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consaquanca of) signed by the ail Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown þ 24b. Ware eutopsy findings availabla prior to completion of cause of death? been sic Completed 24e. Wes an autopsy is certificate has I director, pege 2 s 1 Yes 2 No 1 ☐ Yas 2 ☐ No Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Was case rafarrad to madical 26. Plece of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidanca 6 XOther (Specify) HOSPICE 1 Yas 2♥ No Certification: To funeral 27. Mannar of Deeth 28a. Data of tnjury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Describe how Injury occurred 5 Panding 1 X Natural To the Hospital or Attandir within 24 hours after death.
To the Funeral Director: Al complately filled in by tha ft. 1 ☐ Yas 2 ☐ No Invastigation 2 Accidant 3 Suicida 6 Could not be datarmined 281. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 1D Certifying Physician: To the bast of my knowledga, daath occurred at tha tima, data and place, and dua to the cause(s) and mennar es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the tima, date and place, and dua to the cause(s) and mannar stated. edicai 29a, Cartifian (Check only one) 29b. Signature and title of certifier 29c. Licensp number 29d. Date signed (Month, Day, Year) 1.9 d Ehods 30. Nama and addrass of person who completed cause of death (Item 23e) (Type, Print) 2300 DULANEY VALLEY RD. dr. EDDIE NAKHUDA TIMONIUM, MD 21093 31. Data filad (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95



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6	O	0	-	9

MARTHA DAVIS	State of Maryland / Department of Health and M Certificate of Death	nentai Hygiene Reg. No	
Physicia	1. Decedent's Name (First, Middle, Last)  Martha Bennett Davis	2. Date of Death Month Da SEPTEMBER	3. Time of Death 14, 1998 6:54 PM.
/Medica	Ab City Town or L		. County of Death
Examine		IMORE	NA
Funeral Director	5. Social Security Number 194-26-0388  6. Sax 1	8. Date of Birth (Month, Dey, Yeer) 07-31-14	9. Birthplaca (Steta or Foraign Country) NC
pue M	Usual Residence of Decedenf  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Meryl He ho	Md NA Baltimore		1√ Yes 2 No
or 28e	Md NA Baltimore  100. Streef and Number  105. Zip Code 21256 N Broadway 21213	-	itizen of What Country?
23a	1256 N. Broadway 21213		USA
020 urs s	11. Marital Stalus  12. Was Decedent Evar in U,S. Armed Forces?  1 Never Married 2 Married  1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Year or Dates:  1 Yas 2 No Specify:	pecify Yes or No- b Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
72 hours	15. Decedent's Education (Specify only highest grade completed)  18a. Decedent's Usual Occupation (Give kind of work done during most of work	kina 16b. K	Kind of Business/Industry
21215-0020 d within 72 hours af giene. or than "natural", or the Medical Exert the Medical Exert	Elementery/Secondary (0-12)   College (1-4or 5+)		spital
filed 2		ne (First, Middle, Meider	*
ylanc build be fi Mental H arked ott	Jeff Bennett Emma	Pratt	
Maryland od 2 should be file lith end Mental Hy z7 ia marked other reaumetic avent	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Addrass (Street end Number or Ru		
0 0 0 2 2	Charlie Davis Rt. #1 Box#295 Patr  20a. Method of Disposition 20b. Place of Disposition (Name of		29584  Location - City or Town, State
ages of of h	Burial 2 Cremation 3 Removal from State		
Baltimore, pemil. Pages 1 e Department of Hee Important: if item any lolury or othe page.			, Maryland 21202
Depa Depa Impo	WM.C.March FH		
Physician /Medical Examiner	23a. Part I. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Finat disease or condition resulting in death)  a. Hypertensive and arter cause (Finat disease or condition resulting in death)  b. Cardio vascular Disco		Inferval Between Onset and Death
Box 68760, self certification of the self certification of the self for use as the principle of the self for use as the self fo	Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of):		
P.O. Box	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.	23b. Did tobacco	o use contribute to the cause of death?
* = 9D		1 Tyes	2□ No 3□ Probably 4 nknown
aw requir		24a. Was an autoperformed?  Inspect	24b. Were autopsy findings available prior to complation of ceuse of death?
aft despe		1 ☐ Yes 2	2MNo 1□Yes 2MNo
Of Vital   Physician: The this certificate ral director, pag		th (Check only one)	
hys hys	PLATES 2 INO 1 Inpatient 2 IEH/Outpatient 3 IDOA 4 Invising H	ome 5 X Residenca 28d. Describe how inju	
Vision of Attending P or death.	1 Matural 5 Pending (Month, Dey Year) Injury Work? 2 Accident invasfigation M 1 □ Yes 2 □ No		
V A ret	3 ☐ Suicida 6 ☐ Could not be determined 28e. Piaca of Injury - Af home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street e City or Town, Stet	and Number or Rural Route Number, te)
Hospi 24 hou Funer stely fill			
To the within To the comple	29b. Signatura and fille-of certifier 29c. License number		afa signed (Month, Dey, Year)
1	J. Pertaur, MD O.C.M.E.	SEPI	TEMBER 15, 1998
5	33. Name and all gress of person who completed ceuse of death (Item 23a) (Type, Print)  111 Penn Street, Baltimo	re. Marvlar	nd 21201
State	31. Date filed (Month, Day, Year)  32. Registrar's Signature		

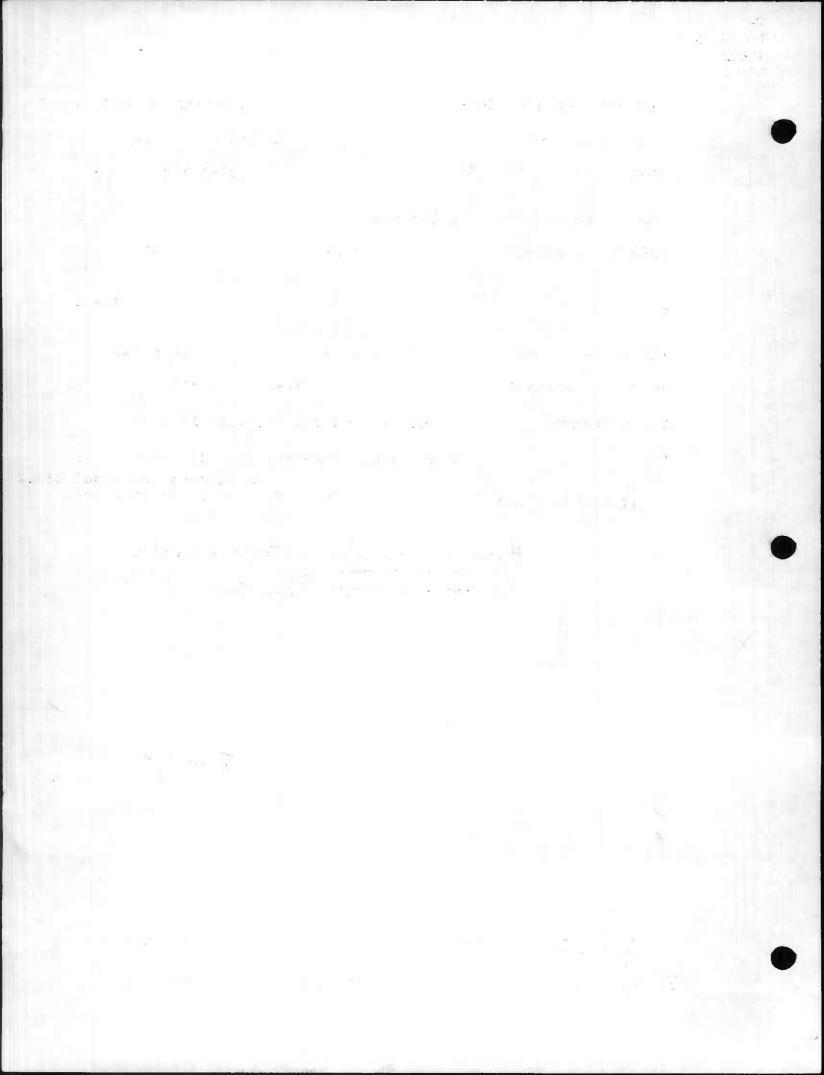
32. Registrar's Signature

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G. Sparks

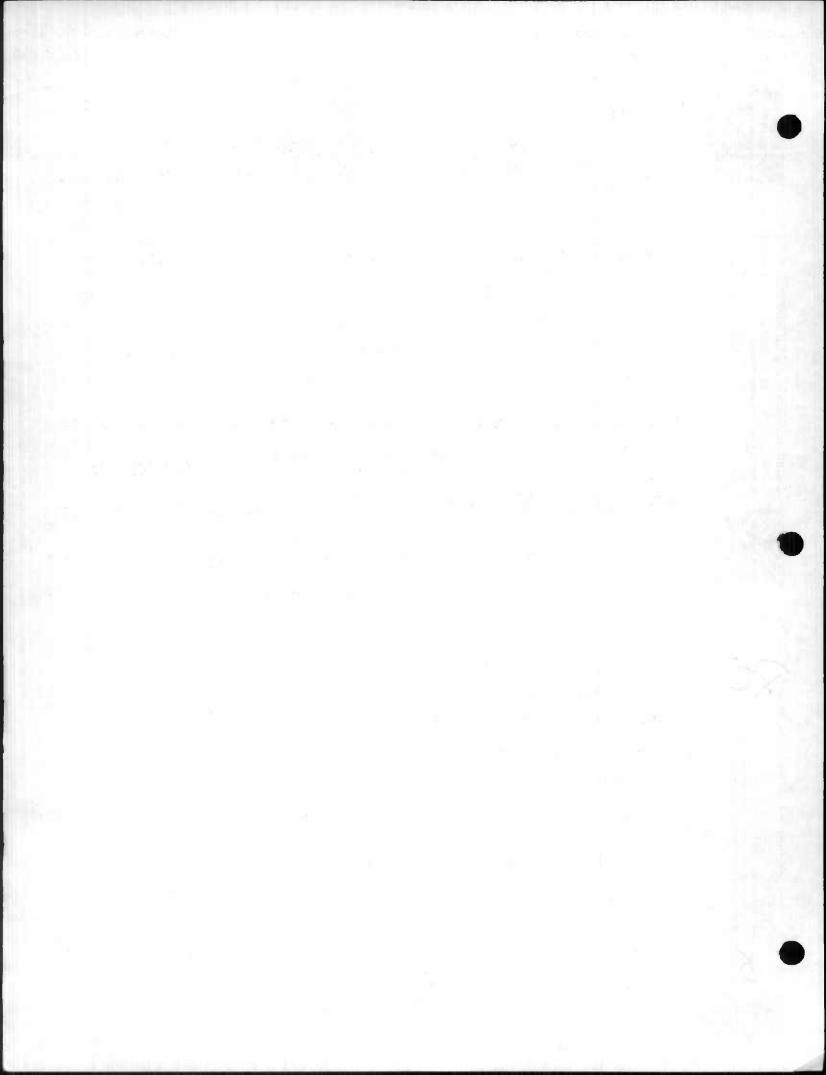
DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene

12		Г. <u>.</u>					rtificate of			Reg. No.	3 28	620
Physic	ian		na (First, Middla, Las						2. Data of Dea Month	Day	Yaar	Tima of Death
/Med	ical	Bever	1	avis				0 0 T	Septembe		1998 6	2 Bm
Exami	ner		(If not institution, give					4b. City, Town, or	Location of Death	4c. County	of Death	
		5. Social Security	HOPKINS Numbar 6. Sa			last birthday	If Undar 1 Yaar	BALTII	MORE	N/A	O Dishalasa	Carte on Francisco
Funeral Director		212-42 Usual Rasidance	-0588	□ м <b>ж</b> .Ж	56	Yrs.	Months Days	Hours Min	8. Data of Birt (Month, De) DEC 3	, 1941	Country) MARYL	(Stata or Foreign
yland		10a. Stata	10b. County		10c. City	y, Town or L	ocation				10d. In	sida City Limits
Mar Greed	cto	MD	N/A		BA	LTIMO	DRE				1	Yas 2□No
or 28	ire.	10e. Street and Nu	imber				10f. Zip Coda			10g. Citizan of	What Country?	
ih w	ie	633 S	. LEHIGH	ST.			21224			U.S.A		
within 72 hours effer death with the Maryland land. I than "netural", or items 23a or 28s-f show the World Eventual to notified at	by Funeral Director	11. Marital Status 1 ☐ Nevar Mar 3 ☐ Widowed	riad 2 Marriad	12. Was Decedan Armed Forcas 1  Yas 2 X If Yas, Giva Yaar or Datas	? No	S. 13.	Was Decedant of If Yas, specify Cub		Specify Yas or No- to Rican, atc.)	14. Rac Bla Specifi	ce - Amarican Inck, Whita, atc.	
2 hou	P		15. Decedant's Ed			16a. Dece	dant's Usual Occu	pation		16b Kind of B	usinass/Industry	
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be filed tal Hygi d other	Be C		(First, Middla, Last)					18. Mother's Na	ma (First, Middle,			
	To	JOHN K	APTAIN					MYRTLE	HEIM			
d 2 should th end Mer 7 Is marke traumatic			lame/Ralationship (7			19b. Mali	ing Address (Stree	t and Number or A	ural Routa Numbe	r, City or Town,	Stata, Zip Code	9)
		COLLEE	N DAVIS/	DAUGHTE		633	S. LEH	IGH ST.	BALTIN	MORE,	MD. 21	224
85=2			position <b>X</b> Cremation 3 □I 5 □ Othar (Specify)		20b. P	P.I.T WC	osition (Nama of matory or other pla RE WASH	INGTON	Data 9/18/98	20c. Location -	- City or Town, S	itata
permit. Pe Depertment Important: any injury		21. Signature Fr	unaral Sarvice Licens	SP8 /		CRE	MATORY 2. Nama and Addr	ass of Facility				
897 29		1020	and of	Donn	, 604	0	HARLES	S. ZEII	ER & SC	ON, INC	c.	
Physician	*	23a. Part . Entar shock, or has	tha disaasa, or comp art failura. List only o	lications that ceuse na causa on aach	d tha daath lina.	n. Do not an	tar tha moda of dy	ng, such as cardia	cor aspiratory ar	HORE	, MD •Appi Intar Ons	21 22 4 val Between et and Death
/Medical Examiner		Immediata Causa disaasa or condition resulting In death)	(Final on	a. Non-	Swa Dua to (or	Ce ras e conse	Cance	r of	lung		- 1	year
ficeta be associted physician and is the burial-transit	Examiner	Sequantially list co		b. Chroni		bstr as a conse	octive quance of):	Pulmon	ary di	sease	- \ \	ears
ificeta be axe physician a		Sequantially list co if any, laading to ir causa. Entar Undo Causa (Disease of that initiated avent	nmadiata erlying Injury	c								
physi the l	edical	that initiated avent rasulting in death)	s Last	V	Dua to (or	as a conse	quance of):					
1	Me			d								
	ian											
2 2 2	ysic	Part II. Other aigni	ficant conditions co	ntributing to daath	but not rasu	ılting in tha u	indarlying causa gi	van in Part I.	23b. Dld to	obacco uae co	ntribute to the	cause of death?
res that the signed by the	by Physician/M	Alcoholi	c cirrhi	isis, es	opha	geal	varice	s, deep	1×1			4 Unknow
Physician: The lew requires the third continues the continues to the conti	Completed	Vein thr	ombosis	, anen	ia,	Uri	nary 7	ract	24a. Was a perfor	an autopsy med?	available	on of ceuse
sician: The lew s certificata has b director, page 2 s		infect	ion						1 🗆 Y	as 2 No	1 🗆 Yas	2□ No
clan	Be	25. Was cesa rafer axaminar?							ath (Check only or	na)		
hysi his c	2	1 ☐ Yes 2 📉	140	Hospitel: 1 Inpat	7	ER/Outpatle	nt 3 DOA Ot	ner: 4 Nursing I	Homa 5 ☐ Resid	ence 6 Oth	ar (Specify)	
f or Attending Peter deeth.  Director: After t	Certification:	27. Mannar of Daat  1 Natural  2 Accident	th 5 Panding Investigation 6 Could not be	28a. Date of Inj (Month, Da	ury ay Yaar)	28b. Tima o Injury	Wo		28d. Describe h	ow injury occur	red	
tal or At its efter d al Direct led in by	Certifi	3 ☐ Sulcida 4 ☐ Homloida	determined	28a. Place of In building, a	jury - At ho tc. (Spacify	ma, farm, st	raat, factory, office		28f. Location (S City or Tow		per or Aural Rou	te Number,
To the Hospital or Attending Physician: within 24 hours after dead within 24 hours after dead or To the Funeral Director After this certifical completely filled in by the funeral director,	edicai	29a. Cartifiar (Check only one)	1 Certifying Phy 2 Medical Exami	elcian: To tha best ner: On tha basis of and mannar s	of axaminat	vledge, daat ion and/or in	n occurred et tha ti vastigetion, in my o	ma, data and place opinion, daath occu	e, end dua to tha curred et tha tima, c	ausa(s) and ma lata and place,	annar as stated. and dua to the c	euse(s)
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5			ass of person who co	ompleted ceusa of	daath (Item	23a) (Type,	Print)			1		
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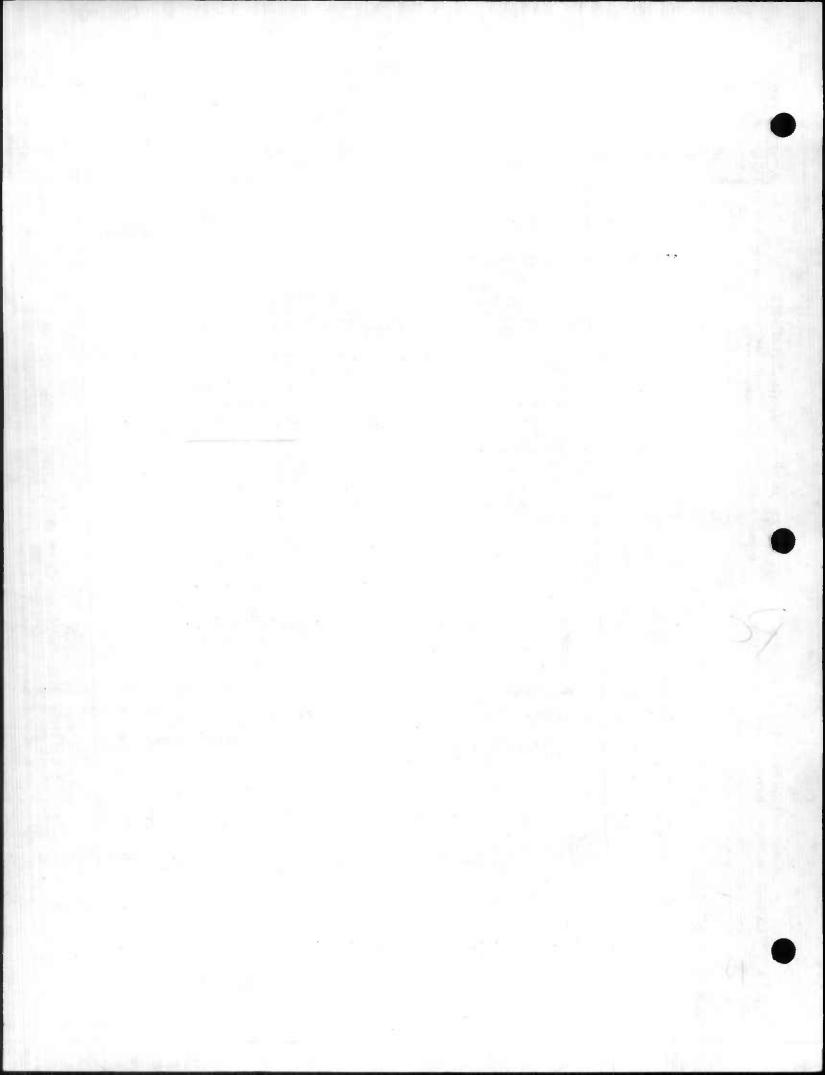


GI	ENE DOVE	ITEMS: #23 PART I, 27, 2	State of Maryland 28A-F PER MEO G763		atment of tificate of	Health a Death	nd Mental Hy	/giene Reg. No.	3 28	3621
	Physician /Medical	Decedent's Neme (First, Middle, Last Gene Dove	)				2. Date of D Month SEPT .	Day 14. 199	Year	3. Time of Death 0656 am
	Examiner	4e Facility Neme (If not institution, give 6 PEBBLE DRIVE	street and number)			4b. City, Tow BROOK	n, or Location of Dee LYN		of Deeth E ARUN	DEL
	Funeral Director	048-66-7401	x 7. Age (In yrs. Ia 31	st birthday) Yrs.	if Under 1 Yee Months Days		4 Hrs. 8. Date of Bi (Month, D Sept.	irth Ay. Year) 12, 196	9. Birthplac Country Mary	e (State or Foreign and
	Maryland febow	Usual Residence of Decedent  10e. Stete 10b. County  Md. Anne Aru		Town or Lo	cation re ( Bro	oklyn	Park )			Inside City Limits 1 ☐ Yes 2 ② No
	or 28st or 28st Direct	10e. Street and Number			10f. Zip Code			10g. Citizen of V		?
020	n 72 hours effer death with the Maryland *natural*, or frems 23a or 28a-f show solical Examines must be notified at leted by Funeral Director	6 Pebble Drive 11. Marital Status 12 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Yeer or Detes:		Was Decedent of f Yes, specify Cul 1 ☐ Yes 2 1 No		in? (Specify Yes or N Puerto Ricen, etc.)		S.A. e - Americen kk, White, etc	
Maryland 21215-0020		15. Decedent's Edu (Specify only highest grad Elementery/Secondary (0-12)	cation le completed) College (1-4or 5+)	(Give kind of work done during most life. DO NOT use retired)					Mecha	
yland	parmit. Pages 1 end 2 should be filed within Department of Health and Mental Hygiena. Important: If Item 27 le marked other than eny Injury or other traumatic event, the Medica.  To Be Compl.	17. Fether's Name (First, Middle, Last)  Curtis Eugene Do	ove				's Name <i>(First, Middle</i> n <b>thi</b> a D. B		10)	
Mar	end 2 sho saith and 1 27 le ma er traum	19e. Informant's Neme/Relationship (T) Cynthia Bohle (Mot			ebble Dr		or Rural Route Num. Iltimore,			
altimore,	Pages 1 er nent of Hea int: If item: iry or other	20a. Method of Disposition  11/2 Burial 2 Cremation 3 F  4/2 Donation 5 Other (Specify)	20b. Pla	metery, crer	sition (Name of matory or other pl		Date 9/18/98	20c. Location - Baltimo		
Balt	Depertriction De	21. Signature of Funeral GETS on Licens	Kevin E. Ecke	r Mc	Name and Add Cully-Po 37 E. Pa	olynial tapsco	Funeral Ave. Balt	Home o., Md.	21225	
	Physician /Medical Examiner   Exa	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in deeth)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or Injury	nARCOTIC AN  Due to (or		HOL INTOXI					nset and Death
Box 68760	ol being	that initiated events resulting in death) Last	Due to (or	as a conseq	uence of):					
P.O.	requires that the death seen signed by the atta- hould be datached to eted by Physician	Part II. Other significant conditions co	ntributing to death but not resul	ting in the u	nderlying cause g	iven in Pert I.		d tobacco use co		ne cause of death?
of Vital Records,	aw requi							is an eutopsy formed?	availe	autopsy findings able prior to pietion of cause ath?
al B	ysician: The list certificate he director, page							Yes 2□No	up	res 2□No
Z Z	Physician: rthis certific iral director,	25. Was case referred to medicel examiner?  CXYes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatier	nt 3 DOA	thor	of Death (Check only		er (Specify)	
	ding Ph h. After thi funaral	27. Menner of Death  1 Netural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury UNKNOW!	28c. Inj W		28d. Describe	how injury occur		
Division	아 등 등 등	3 Suicide 6 🕅 Could not be 4 Homicide determined	28e. Piace of Injury - At hor building, etc. (Specify)	ne, ferm, str	eet, fectory, office	3	City or T	(Street and Numbown, State) LE DR., BR(		
	To the Hospital within 24 hours of the Funeral completely filled		sician: To the best of my know ner: On the besis of examinetic and manner stated.							
	Vithir Comp	29b. Signature and title of certifier	John			C.M.E		29d. Date signe SEPT.	14, 19	
	State	30. Name and address of person who control of the state o	ompieted cause of death (Item  1 32. Registrar's Signatu	.11 Pe	nn Stree	t, Bal	timore, Ma	aryland 2	21201	

LANGER DEPOSITE myod en all de la State State System annualizability Supress, Total States Par removed distribution of the second section 

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend: #20b F	er FH Film G763 9-18-98RC	Cei	tificate of Death		ig. No. 50 2	8622				
Physician	1. Decedant's Nama (First, Middla, Last)  Eugenia Ruby Davidso	on		2. Data of Death Septembe	r <sup>D</sup> ¶ <sup>y</sup> 4 1998′	3. Time of Death 8:45 AM				
/Medical Examiner	4a Facility Name (if not institution, give street and		4b. City, Tow	m, or Location of Death	4c. County of Death					
	Prince George's Hospit	al Center	Chever	1v	Prince Geo	rge's				
Funeral Director	5. Social Security Number 6. Sex 1 M 2 √ 5 € 5 5 3 4 9 4 6 3	7. Age (In yrs. last birthday)	If Under 1 Year If Under 2 Months Days Hours	4 Hrs. 8. Data of Birth (Month, Day, May 28,	Year) 9. Birthp	lace (State or Foreign try) ornia				
aryland show	Usual Rasidance of Decedent  10a. Stata 10b. County	10c. City, Town or Lo	cation		11	Od. Inside City Limits				
with the Maryland a or 28a-1 show the notified at	Maryland Prince George'	s Bowie				1 √2 Yas 2 No				
or 28s-f se norther	10e. Street and Number		10f. Zip Code	10	og. Citizen of What Coun	try?				
	1300 Parkington Lane		20716		nited State					
2-0020 72 hours after death v naturel, or flems 23 feel Engrices must	1 Nevar Married 2 Married 1 Yes,	Forces?	Was Decedent of Hispanic Origing Yas, specify Cuban, Maxican, I ☐ Yes 2 ☐ No Specify:	m? (Specify Yas or No- Puarto Rican, atc.)	14. Race - Americ Black, Whita, of Specify: Whit	etc.				
1	15. Decedent's Education (Specify only highest grade complete  Elementary/Secondery (0-12)  College	ife. (1-4or 5+)	dent's Usuel Occupation kind of work done during most OO NOT use retired)		16b. Kind of Business/Industry U.S. Government					
be filed with tal Hygiena. d other than event, the	17. Fathar's Nama (First, Middla, Last)	Execut	ive Secretary 18. Mother	's Neme (First, Middle, M		ient_				
2 2 2 2 D	William B. Storer			llie M. Pee						
2 sho	19a. Informant's Name/Ralationship (Type, Print)		ng Address (Street end Number			Code)				
1 and 1 and 1 and 27 wher tr	Marilyn Davidson/daught 20a. Mathod of Disposition	20b. Place of Dispo	07	ver Spring,	MD 20901 Oc. Location - City or To	wen State				
0 8257	1 Burial 2 Cremation 3 Removal fro	complete and	netory or other place)		aldorf, MD	wii, Otata				
DERIUMOTE, permit. Pages 1 ar Department of Hea important: if item 2 any injury or other ance.	21. Signatura of Puneral Service Licentee	22 F	Nama and Addrass of Facility Robert E. Evans	Funeral Ho	me, Inc.					
	23a. Part T. Entar tha disease, or complications that shock, or heert failure. List only ona cause or	at caused the death. Do not ent	.6000 Annapolis er the mode of dying, such es c	Rd. BOW1e ardiac or respiratory arre	, MD 20715	Approximate triterval Between				
Physician /Medical Examiner	Immediata Causa (Final disassa or condition	Recyneut	. /	4.4		Onset end Death				
	rasulting in death)	Due to (or as a consec	-0	0		2 0000				
buted ansit	Due to (or as a consequence of):  Massive acute acutenon myo cardial or in maintained events  Due to (or as a consequence of):  Massive acute acutenon myo cardial or in maintained events  Due to (or as a consequence of):  In faction  Severe acutenon myo cardial or in maintained events  Severe acutenon myo cardial or in faction or in fac									
DA	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c	Severe dy	frese Corone	duy alker	oschrosio	years				
Medic	that initiated evants rasulting in death) Last	Dua to (or as a consid	uence of):	0		0				
auth certill attanding for use a	0									
hat the da ed by the ed datached	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in Part I.		bacco use contribute to					
signed by the d be deteched by Phys	acute pulmonary	edema c	recite reform	along 10 Ye	s 2□ No 3⊠ Prot	bably 4 Unknown				
The law requires that the death certificate has been signed by the attending page 2 should be detached for use a Completed by Physician/Me	failure, Carol	logenie sho	k	24a. Wes ar perform	ned? evi	are autopsy findings ailable prior to mpletion of cause death?				
The law ate has page 2.		V		1 □ Ya	s 20 No 10	Yes 2 No				
ysician: The	25. Was casa rafarred to medical axeminar?	1		of Death (Check only one	9)					
Physician: This cartificial director.	1 Yas 2 No Hospitel: 1∫	Inpatient 2 ER/Outpatier		sing Homa 5 Raside		(y)				
After Fund	2 Accidant invastigation 3 Suicida 6 Could not be	te of Injury onth, Day Year)  28b. Tima of tnjury  ace of Injury - At home, farm, str	28c. Injury at Work?  M 1 Yes 2 N		w injury occurred reet and Number or Rura	Il Route Number.				
Series of inches	4 Homicida detarmined bui	ilding, etc. (Specify)		City or Town						
	(Check only 2   Medicat Examiner: On the	the best of my knowledge, death basis of examination and/or in anner stated.	occurred at the tima, data and restigation, in my opinion, deeth	place, and dua to the can occurred at the time, de	use(s) and manner as state and place, and due to	tated. o tha cause(s)				
Withir Comp	29b. Signatura and title of certifier		29c. License number	25	9d. Data signed (Month,					
1.0	121 skind	ag no	02472	0	9-14-	18,				
10		use of death (Item 23a) (Type, LOVEN ROC		erk. Rus	d 2078	5				
State Registrar	31. Data filed (Month, Dey, Year) SEP 1 8 1998	. Registrar's Signature	park							



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) Month Day **Physician** MARTE ECK September 17,1998 6:30 am CATHERINE /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, giva street and number) Examiner RIVERVIEW NURSING CENTRE Essex Raltimore if Undar 1 Yaar | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Sociel Sacurity Number 7. Aga (In yrs. lest birthday) Birthpiaca (Stata or Foreign Country) **Funeral** Deys Hours Min 1 ☐ M 2 🖾 F Yrs. 214-14-9296 87 Dec. 11,1910 Maryland **Director** Usuai Rasidence of Decedent the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show 7 is marked other than "natural", or itema 23a or 28a-f sho traumatic event, the Modical Examinar must be noutled at Yas 2 No Director N/A Baltimore 10e, Street and Number 10f. Zip Coda 10g. Citizen of What Country? 3414 Noble Street U.S.A. 21224 Funeral filed within 72 hours after deeth Hygiena. 12. Wes Decedent Evar in U,S. Armad Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) Race - Amarican Indien, Biack, White, atc. 11 Marital Status 1 Yas 2 No If Yas, Giva Yaar or Dates: 1 ☐ Nevar Married 2 ☐ Married 1 Yas 2 No Specify: Specify: White à 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health end Mantal Hygien important: if item 27 is marked other that any Injury or other traumatic event, traumatic event, traumatic event, traumatic event, traumatic 8th Homemaker Own Home 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Surnama) George Bauernschab Catherine Bennett 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stete, Zip Coda) August Wehrman / Son 3414 Nobel Street, Baltimore, Md. 21224 20b. Plece of Disposition (Nama of cematary, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 9-21-98 Buriai 2 Cramation 3 Ramoval from Stata
Donation 5 Othar (Specify) Sacred Heart of Jesus Cemetery Balto., Md. 21222 21. Signeture of Funeral Service Liq 22. Name and Addrass of Facility Moran-Ashton-Dabrowski Funeral Home, Inc. 3000 E. Baltimore St., Baltu.

23a. Parti. Entar tha disaasa, or complications that caused the death. Do not entar the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. 3000 E. Baltimore St., Balto., Md. 21224 Approximete Intarval Between Onset end Deeth **Physician** Immediate Causa (Final disaese or condition rasulting in death) /Medical · Arteriosclerskie Cormony Uprwlae Direare YM Examiner Due to (or es a consequence of) Examiner Sequantially list conditions, if any, leeding to immadiata ceuse. Enter Underlying Cause (Disaasa or Injury that Initiated avants rasulting in death) Lest physician and Dua to (or as a consaquance of) Division of Vital Records, P.O. Box 68760, Dua to (or as a consaguanca of) **Physician/M** the attenda The lew requires that the death Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Sylutive Heart Failure, Kenalines Eficiency, old cerebro. 2 24a. Was an autopsy performed? 24b. Wera autopsy findings eveileble prior to Completed Varestar accident. menong ema. peen completion of ceuse of deeth? certificate has 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No Physician: 25. Was cesa rafarred to medical axaminar? Be 26. Placa of Daath (Check only ona) Othar: 4 Nursing Homa 5 Pasidance 6 Othar (Specify) Hospital: 1 ☐ Yas No P 1 Inpatient 2 ER/Outpatient 3 DOA this funeral o 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? Certification: 24 hours after death.

Funeral Director: After t 5 Panding investigation or Attending 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Piece of Injury - At home, farm, straat, factory, office building, atc. (Spacify) 4 Homicide 1 Certifying Phyeiclan: To the best of my knowledge, death occurred at the time, date and piace, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner steted. 29a. Certifiar edical completely (Check only one) within 2 29c. Licensa number 29d. Data signed (Month, Day, Year) 29b. Signetura end titia of certain Muael Lundomy D19667 30. Nama and addrass of person who complated causa of daeth (item 23a) (Type, Print) DR. **MI**CHAEL SCHWARTZ 5517 "A" RITCHIE HIGHWAY BALYIMORE MARYLAND 31. Data filed (Month, Day, Year) 32. Registrer's Signeture State

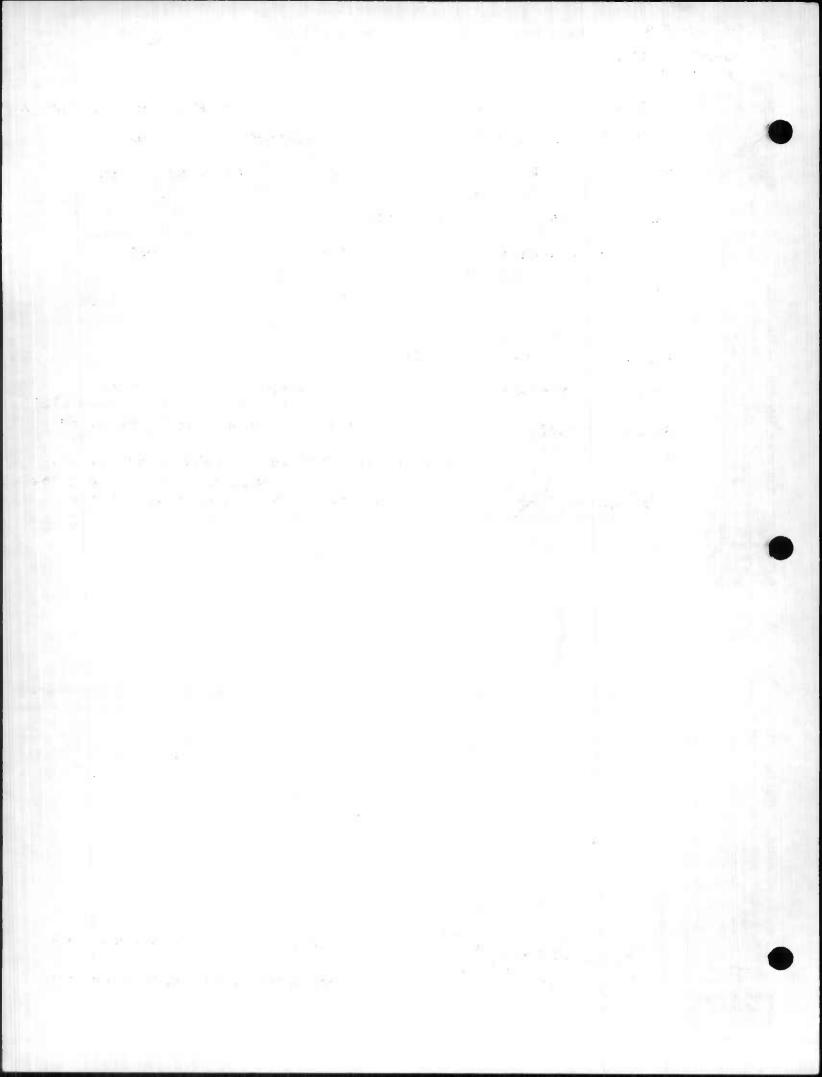
Registrar **DHMH 16 Rev 6/95** 

SEP 1 8 1998

The Real State of the last Part of the second second 

Physician	TEMS: #23 PART I,  1. Decedent's Name (First, Middle, Li		G764 Ce	rtificate of	Death	2. Date of Deat	th	3. Time of Death
/Medical	Shemal	Fletch	er			Month SEPTEM	BER 15	1998 12:25
Examiner	4a Facility Name (If not institution, git UNION MEMORIA				4b. City, Town, or Loc BALTIMORE	ation of Death	4c. County o	
Funeral Director	NA	Sex 7. Age	(In yrs. last birthday) Yrs.	If Under 1 Yeer Months Days 1 9	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 08-06-	Year) 98	Birthplace (State or Foreit Country)     M D
ahow	Usual Residence of Decedent  10e. State 10b. County  MD NA		10c. City, Town or Lo					10d. Inside City Limi
28a-f notifie	10e. Street and Number		Daicinc	10f. Zip Code		1	0g. Citizen of W	
23a o unt be	3852 Elmora A	venue		2121			USA	
in realin and Mental hygiene.  Item 27 is marked other than 'natural', or items 23a or 28a-f show other traumstic event, the Medical Examinet must be notified at To Be Completed by Funeral Director	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced	12. Was Decedent E- Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of It If Yes, specify Cub 1 ☐ Yes 2 No	dispanto Orlgin? (Specen, Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)	Biack	American Indien, White, etc.
ner than "nature it, me Wedcell Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Decedent's Usuei Occupatio (Give kind of work done duri life. DO NOT use retired)		during most of workin		16b. Kind of Bus	siness/Industry
omp	Elementery/Secondary (0-12) Infant	College (1-4or 5+	Chil		0)	Chi		
d other	17. Father's Name (First, Middle, Las.				18. Mother's Name	(First, Middle, I	Maiden Sumame	
marked o		etcher			Sharon			ward
theath end them 27 is me other traume	19a. Informant's Name/Relationship  Sharon Howar 20e. Method of Disposition		3852	Elmora  Sition (Name of	Avenue	Baltin	nore, M	State, Zip Code) 2121  Staryland  City or Town, State
ant: If he	X1 Donation 5 Other (Speci			matory or other ple	rdens 09	-19-98	B Dund	Balk, MD.
Department of Important: If It any Injury or once.	21. Signature of Funeral Servica Lice	nsee	22	2. Name end Addre	4	timore	e, Mary	land 21202
ysician Medical aminer	Immediate Cause (Final disease or condition resulting in deeth)	0.	NFANT DEA		OME			Onset and Death
ust as the found-transit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	C	ue to (or as a consecue to (or es a consec					
igned by the attending be detached for unital by Physician Me	Part II. Other algniffcant conditions	contributing to death but	not resulting in the u	inderlying cause gi	ven in Part I.			tribute to the ceuse of des
2 should						24a. Wes a perform	n autopsy med?	24b. Were autopsy finding available prior to completion of cause of death?
							es 2 No	1 ☑Yes 2□ No
irector	25. Was case referred to medical examiner? 1 ★ Yes 2 No	Hospital:	t 2 ER/Outpetie	nt XXDOA Ot	26. Place of Death her: 4 Nursing Hom			v (Snacihi)
am. r: After this c e funeral dire ation: To	27. Manner of Deeth  1 Natural  2 Accident investigation	28e. Date of Injury (Month, Day	28b. Time o	at 28c. Inju			ow injury occurre	
	3 Suicide 6 Could not to determined	28e. Placa of Injur building, etc.	y - At home, farm, st (Specify)	reet, factory, office	2	8f. Location (Si City or Town		er or Rurel Route Number,
od in by the f		nysician: To the best of	my knowledge, deet	h occurred at the ti	me, date end plece, a opinion, death occurre	nd due to the c	ause(s) end mer ete end placa, a	nner as stated.
A thours are losan.  • Funeral Director: Affect pletely filled in by the funeral edical Certification:	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	miner: On the basis of e and manner state	ed.	ivestigation, in my				ind dde to the cadse(s)
Winn 24 hours are reen. To the Funeral Director. After thi completely filled in by the funeral Medical Certification: 7	29a. Certifier (Check only one)  1 Certffying Pl 2 Medical Example 1  29b. Signature and tills of cartifier	miner: On the basis of eand manner state	1D	29c. Licen	se number	2	9d. Date signed	(Month, Day, Year) ER 15,1998
To the Functed Directo completely filled in by the Medical Certific	29b. Signature and tills of cartifier	completed sause of de	1D	29c. Liceno	se number	2	9d. Date signed	(Month, Day, Year)

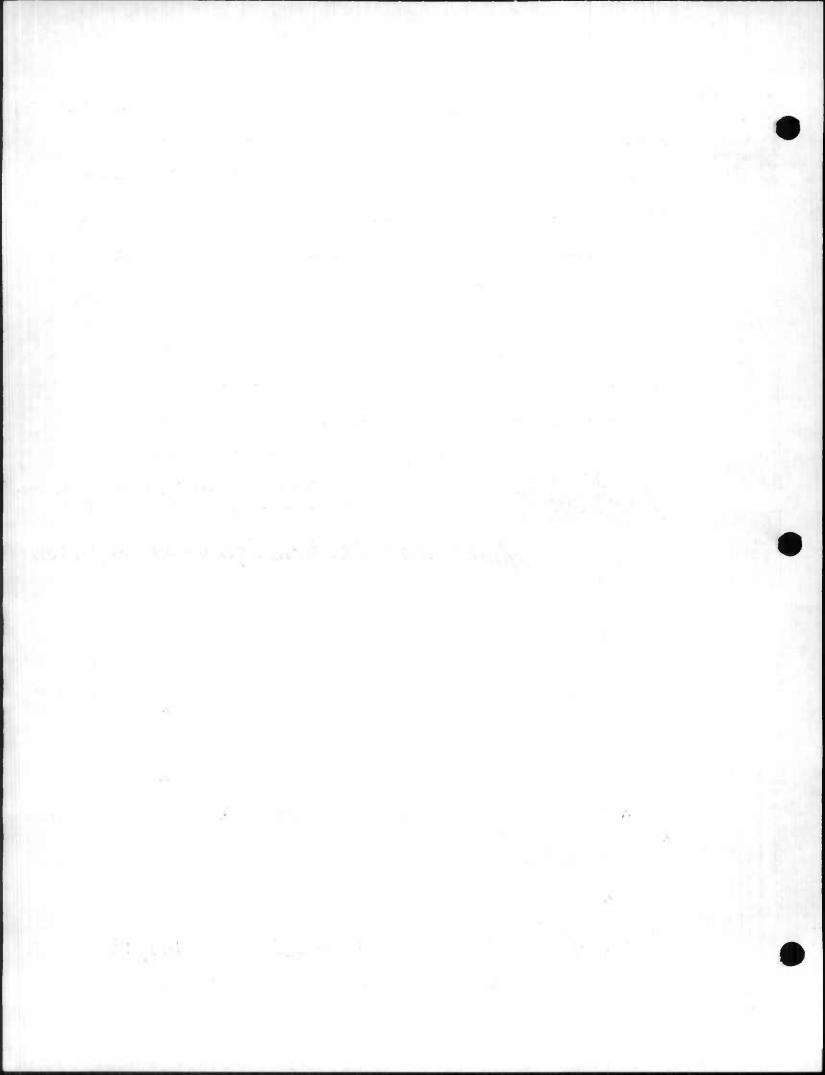
DHMH 16 Rev 6/95



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physicia	an	Decedent's Neme (First, Middle, Last)								2. Dete of De Month	Dey	Yeer	3. Time of Deet
/Medic	-	Marc Feldman								SEPT.	16,	1998	10:00
Examin	er	4e. Fecility Neme (If not institution, give street and number)							Location of Deet				
		6 Boulder Lane 5. Sociel Security Number 6 Sex 7 Age (In vrs. lest hirthdey) If Under 1 Yo							altimo Under 24 Hrs				
uneral irector	Be Completed by Funeral Director	5. Sociel Security Number  414-76-9733  Usual Residence of Decedent  6. Sex 1							lours Min.	(Month, Da	1948		plece (Stete or Forentry)  nessee
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ottra			N/A	/A E		Baltimore							^
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s 23		6 Bould	10 Was Dans							USA 14. Rece - American Indian,			
naturel', or items 23e or 28e-f show idical Examiner must be notified at		1 Never Merried 2 Married 3 Widowed 4 Divorced		Armed For 1 Tes If Yes, Giv	1 ☐ Yes 2 X No		If Yes, specify	Decedent of Hispanic Orlgin? (Specify Yes or Ns, specify Cuben, Mexican, Puerto Rican, etc.)  Yes 2X No Specify:			Bleck, White, etc.  Specify: White		etc.
		15. Decedent's Ed		ducation	ucation 1		16e. Decedent's Usuel Occup		upetion		16b. Kind of Business/Industry		
			ify only highest gr	rede completed)	de completed)  College (1-4or 5+) 5+		(Give kind of work done du life. DO NOT use retired)		ne during most of working red)		Education		adolly
than the		Elementery/Second 12											n
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De o	OB							Phv1	llis Salter				
t: If itsm 27 is mark y or other traumati	-	19e. Informent's Name/Relationship (Type, Print)  19b. Mailing Address (Street et al., 19b. Mailing Address (Street et al.					reet end				m, Stete, Zin	Code)	
		Ted Feldman - brother					Chicken					3721	
		20e. Method of Disp			20b.					Data	20c. Locatio		
			☐ Cremetion 3 ☐ 5 ☐ Other (Special	(Removal from State v)  20b. Place of Disposition (Neme of cemetery, cremetory or other Temple Cemeter				0/10/0		Nashville, Tenn.		Tenn	
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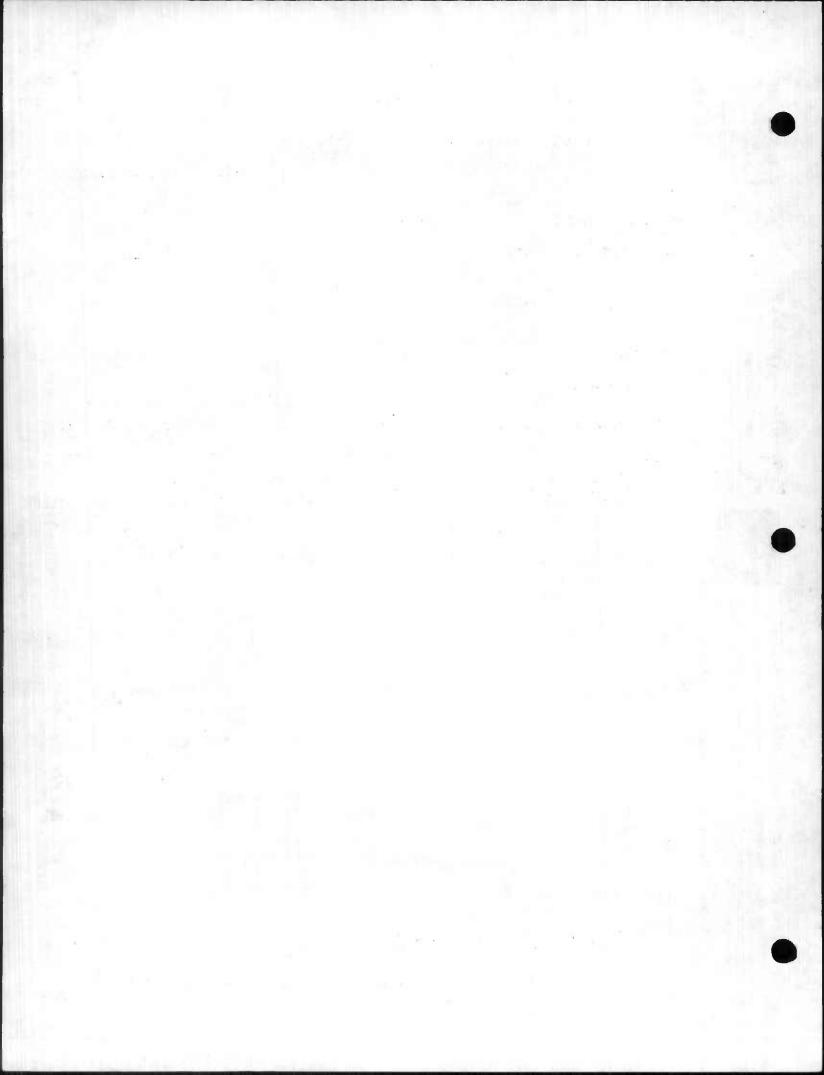
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State of Maryland / Department of Health and Mental Hygiene

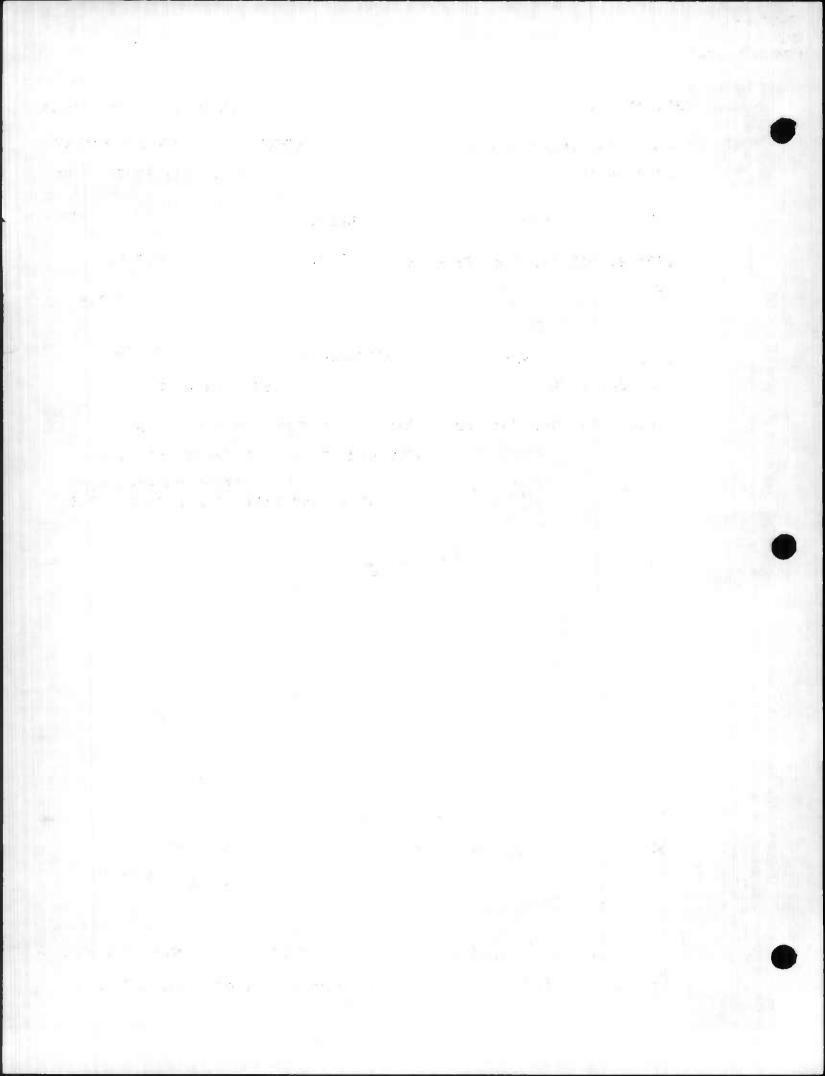
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBLE Day Fanches **Physician** 13 1998 5-10 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number, 4c. County of Death **Examiner** MORTHWEST 405 F LENTER BALTIMORE ITAL RANDAUMONN If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) **Funeral** 12 M 20 F 078-01-3210 Director SEPT 6,1915 NORTHAMPTON, NY Usual Residence of Decedent the Maryland 10a. Slale 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show must be notified at Yas 2 No Director FLORIDA MANATEE ELLENTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 549 MONTEGO LANE SOUTH Herns 23a 34222 U.S.A. death Funeral 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑Yes 2 ☐ No If Yès, Give Year or Dales: Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Menial Hygiene. Important: If Item 27 is marked other than "natural" any injury or other traumatic average. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: PV WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12Th GRADE BARGE CAPTAIN MARATIME 17. Fathar's Name (First, Middle, Last) 18. Molher's Name (First, Middle, Maiden Sumame) Be RICHARD FANCHER CLAISSA MAY KING 19a. Informani's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLADYS R. FANCHER (WIFE) 549 MONTEGO LANE SOUTH - ELLENTON, FLORIDA 34222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Localion - City or Town, Slate 20e. Mathod of Disposition Dala 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BALTO/WASHINGTON CREMATORY 9/16/98 4 Denalion 5 Other (Specify) LAUREL, MARYLAND of Filmeral Service Licensee 22. Name and Address of Facility HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximete Interval Between Onsel and Deeth Physician Tedical Immediate Cause (Final disaasa or condition resulting in death) CARDIOVASCULAR ATHERO SCLEROTIL DISENSE Examiner Due to (or as a consequence of): Examiner burial-transit the death certificate be executed Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of): USa Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23b. Did tobacco use contribute to the cause of death? P.O. 4 Unknown 1 Tyes 2 No 3 Probably þ Division of Vital Records. The law requires 24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to completion of cause of death? Completed 1 Yes 1 Yes Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) 1 Yas 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To ER/Outpatient 3 DOA 1 Inpatient this funaral 27. Manyfer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural
2 Accident e Hospital or Attending n 24 hours and death. Ne Furgers Officeror: Aft casien mise in by the fur 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Within To the comple 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certific SEPTEMBER 13, 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EANDALL'S TOWN, MARYLAND POTHKIN 5401 MICHAEL COURT OLD ROAD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 8 1998 SEP Registrar



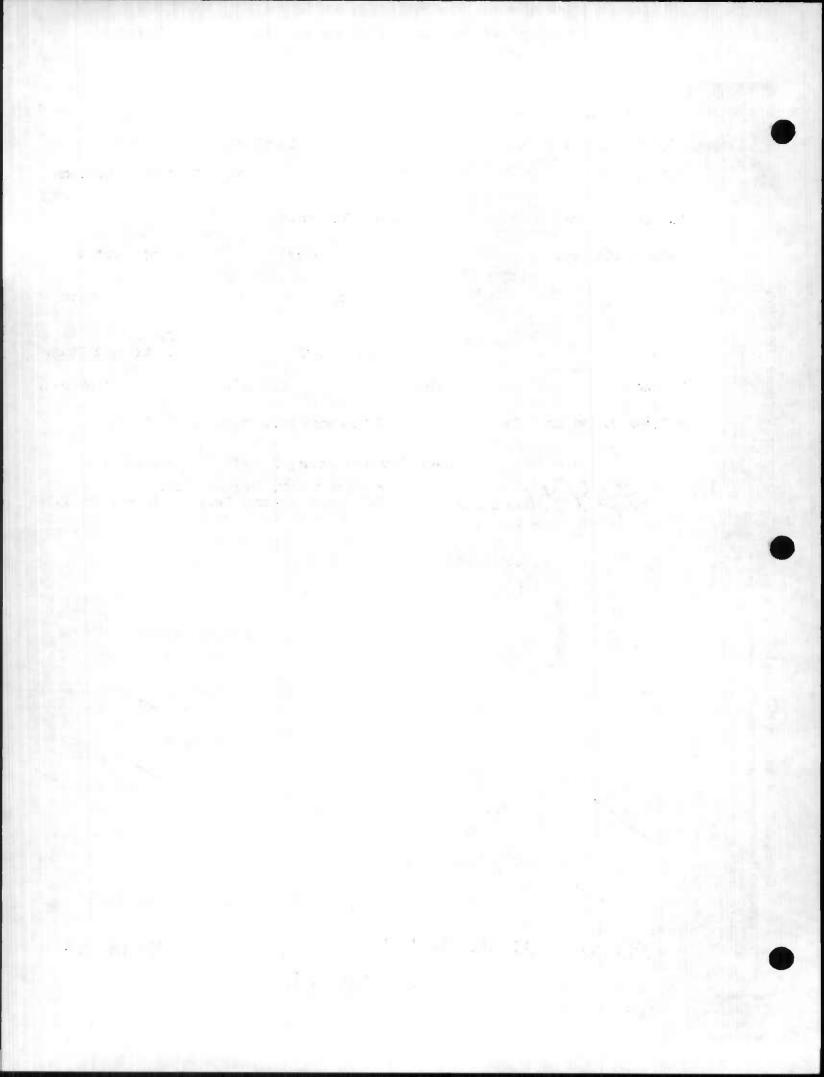
# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

	1. Decedant's Name (First, Middle, Last)	Reg. No. 2862
Physician	DEVRIN J. FORD	Month Day Yaar SEPTEMBER 15, 1998 1459PM
/Medical Examiner	4a Facility Nama (If not institution, giva street and number)  4b. City, To	wn, or Location of Death 4c. County of Death
	ATLANTIC GENERAL HOSPITAL BER	LIN WORCESTER COUNTY
Funeral	5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) H Under 1 Yeer If Under 2 2 0 0 0 4 4 7 1 0 \$\sqrt{D}\$ M 2 \sqrt{F}\$ 1 8 Yrs. Hours	Min. (Month, Day, Yaar) Country)
Director	220-94-4719 ** 18 Yrs.   Wall Residence of Decedent	April 12, 1980 MD
statistics of theme 23a or 28a-f show statistics must be nutried at sted by Funeral Director	10a. Stata 10b. County 10c. City, Town or Location	10d. Insida City Limits
28a-f sh pormed rector	MD N/A BALTO	XXYas 2□No
Director	10e. Street and Number 10f. Zip Coda	10g. Citizan of What Country?
<u></u>	1524 E. BALtimore st 2n fl #B 21231	U.S.A.
Funeral	11. Maritel Stetus  12. Wes Decedent Ever in U,S. Armed Forcas?  13. Was Decedant of Hispanic Orling if Yas, specify Cuben, Mexican	gin? (Specify Yes or No- n, Puarto Ricen, atc.)  14. Race - Amarlcen Indian, Black, White, etc.
by F	1 Never Married 2 Married 1	Specify: BLACK
Pa	15. Decedent's Education 16a. Dacedant's Usual Occupetion	16b. Kind of Business/Industry
ompie	(Specify only highast grada complated)  (Give kind of work dona during most life. DO NOT usa retired)  Elementery/Secondery (0-12)  Collega (1-4or 5+)	t of working
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2		VERONICA WOODS
		er or Rural Routa Number, City or Town, Steta, Zip Coda)
	20a Mathod of Disposition 20b. Place of Disposition (Nama of	RE ST 2nd FI. #B 20c. Location - City or Town, Stata
To Be C	b Buriel 2 □ Crametion 3 □ Ramovel from State 4 □ Donation 5 □ Other (Specify)	9-22-98 BALTO, MD
DUCE.	21. Signature of Funaral Sarvice Licansaa 22. Nama and Addrass of Facilit	y DEEDE BUNEAU HOVE
BUCE	Later and Hottle 1129 N. CARO	BETTS FUNERAL HOME LINE ST BALTO, MD 21213
	23a. Pert1. Entar tha disaasa, or complications that causad the deeth. Do not antar tha mode of dying, such as shock, or haart failura. List only one cause on each line.	
iner Examiner	Immediate Causa (Finel disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions.  Due to (or as a consequence of):	
edicai	Sequentially list conditions, if any, laading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated avants rasulting in death) Last  Dua to (or as a consequence of):  Dua to (or as a consequence of):	
/ Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	. 23b. Did tobacco use contribute to the cause of death?
hys		1 Yes 2 No 3 Probably 4 Unknown
by		24a. Wes en autopsy 24b. Were autopsy findings
Completed		performad? eveilable prior to completion of cause of daath?
		1 X Yas 2 No 1 Yas 2 No
o Be	axaminar? Hospital: Other	of Daath (Check only ona)
n: To	27. Mannar of Death 28e. Date of Injury 28b. Tima of 28c. Injury et	rising Homa 5 ☐ Rasidanca 6 ☐ Other (Specify)  28d. Dascribe how injury occurred
ation	1 Natural 5 Panding (Month, Dey Year) Injury Work? 2 Accident Invastigation 9//5/99 14:12 BM 1 Yes 2	No subject drowned
Certification:	3 Suicida 4 Homloida 6 Could not be determined 28e. Plece of Injury - At homa, farm fatreat, factory, office building, atc. (Specify)	28f. Location (Streat and Number or Rural Route Number, City or Town State) of Finces
edicai C	29a. Certiflier (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data an (Check only one)  2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, data and mannar stated.	d place, and dua to the cause(s) and manner as steted.
completely filled in by the fune Medical Certification	29b. Signature end title of cartifiar 29c. License number	29d. Data signed (Month, Day, Year)
,	Mennis V. Christean O.C.M.	E. SEPTEMBER 16, 1998
	30. Name end addrass of person win plated ceusa of death (Itam 23a) (Type, Print)	Baltimore, Maryland 21201
State	31. Data filed (Month, Day, Year) 32. Registrar's Signatura	buttumote, ratytana 21201
Registrar	SEP 1 8 1998 Server B. sparks	



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** 8:05am ATHERINE GIENN SEPTEMBER 16 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Baltimore
If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Devs Hours Min. (Month, Day, Year) n/a Liberty Medical Center 7. Aga (In yrs. last birthday) 5. Social Security Number 9. Birthplaca (Stata or Foraign **Funeral** 1□M 25 F 89 Yrs. 212 10 4950 March 18,1909 Director Maryland Usuel Rasidance of Dacedant with the Marylend 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Manyle Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23s or 28s-f show may injury or other treumatic event, the Moncel Examinal must be notified anone. 1 Yes 2 No n/a Maryland Baltimore Directo 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21237 2000 Odell Ave. United States Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puarto Rican, atc.) 14 Race - American Indian 11. Maritel Status Bleck, White, atc. 1 Yas 2 No If Yas, Giva Year or Datas: 1 Navar Married 2 Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: White by 3 Widowed 4 X Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade complated) Retail / Elementary/Secondary (0-12) Collega (1-4or 5+) Sales Clerk Department Store unknown 18. Mothar's Name (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Webb (Unknown) Catherine (Unknown) 2 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) William M. Gainor / Son 17929 Masemore Rd., Parkton, MD 20b. Place of Disposition (Nama of camatary, crematory or other placa) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Burial 20 Cramation 3 Removal from Stata 4 Donation 5 Other (Specify) Green Mount Crematory 9/19/98 Baltimore, MD 22. Nama and Addrass of Facility CAFA Stephen D. Lohrmann P.A. tisle Xohman 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medicai Examiner Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Dua to (or es e consequence of) physician ar P.O. Box 68760 Physician/Medical Due to (or es e consequence of): rasulting in daath) Last 88 esn 23b. Did tobacco use contributa to the cause of death? ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, ò 24b. Wara autopsy findings available prior to complation of ceuse of death? 24a. Was an autopsy performed? Completed peen : has 1 Yes 2DNo 2 DINA 1 ☐ Yas certificate or Attending Physician: 25. Was casa rafarrad to medical axaminer? Be 26. Placa of Daath (Chack only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Dipatiant 2 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) funeral 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Time of 28c. Injury al Work? Certification: After 1 Natural 5 ☐ Panding 1 ☐ Yas 2 ☐ No Invastigation efter death. Director: A 2 Accidant 6 Could not be datarminad 3 ☐ Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 24 hours efter Funeral Direct pletely filled in b 4 Homicida the Hospital 1 Cartifying Physician: To the bast of my knowledge, death occurred at tha time, data and place, and due to the cause(s) and manner as stated. edicai 29a. Cartifian 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29c. Licansa number 29d. Data signed (Month, Day, Year) 10 ile III M.D. 12 who complated causa of daath (Itam 23a) (Type, Print) 21215 31. Data filed (Month, Day, Year) SEP 1 8 1998 32. Registrar's Signatura State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Tima of Deeth **Physician** Month Mary Ann Gable September 11, 1998 9:30 AM /Medical 4e. Fecility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Westminister Nursing and Rehab Center Westminister Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral**  Birthplece (State or Foreign Country) 1 M 2 SF Days Hours 80 236-18-4200 Director May 15, 1918 West Virginia Usuat Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene. Important: if them 27 is marked other then "nature!, or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified once. 10a. Stete 10b. County 10c. City, Town or Location 10d. tnside City Limits **Funeral Director** Maryland Carrol1 Westminister 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1234 Washington Road 21157 U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No It Yes, Give Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ White Specify: 3 Widowed 4 Divorced Yaar or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 State Hospital Nurse 17. Fethar's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Meiden Sumema) Richard Lee Ramsey Runa Alice Williams P 19e. tnformant's Neme/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Sara Martin/daughter 1654 Ridge Road, Upperco, Maryland 21155 20a. Method of Disposition 20b. Place of Disposition (Neme of 20c. Location - City or Town, State cemetery, crametory or other place) 1 ☐ Buriat 2 ☐ Cramation 3 ☐ Removal from Stata 4 Donetign\_5 ☐ Other (Specify) Ronald S. Wade, 22. Name end Addrass of Fecility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

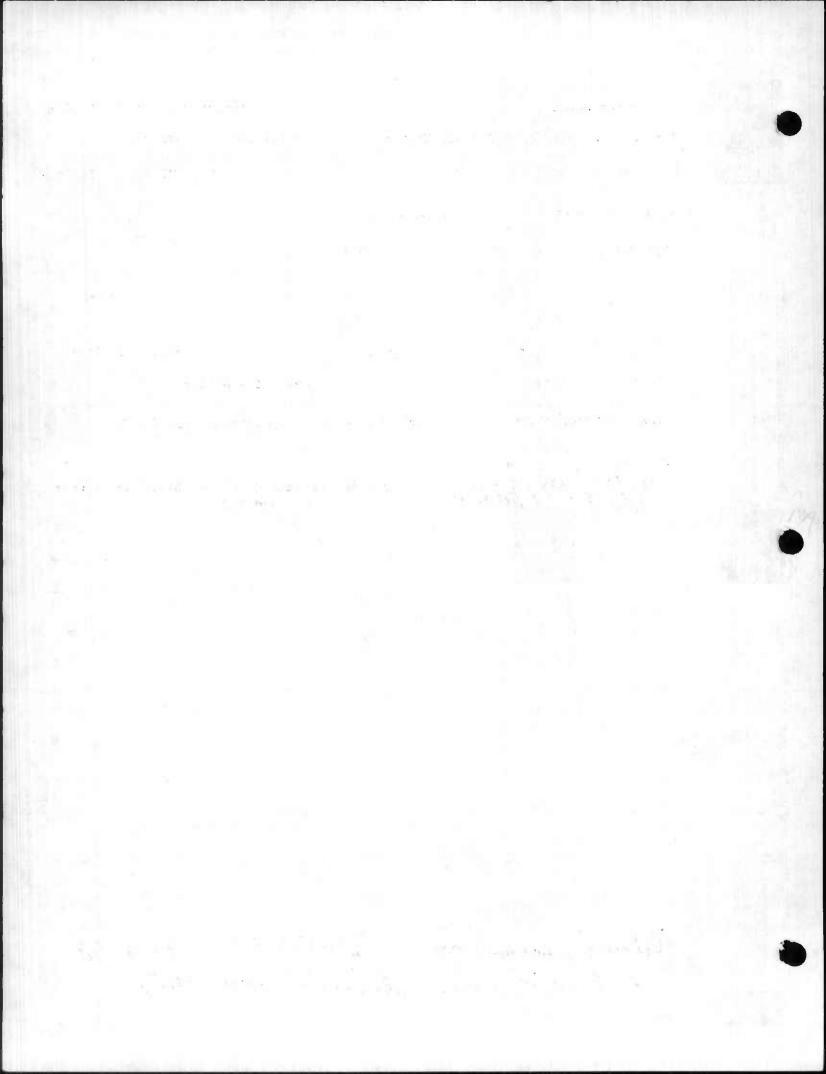
23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart teilure. List only one cause on each line. Physician tmmediate Cause (Final disease or condition resulting in death) /Medical Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if any, teading to immediate cause. Entar Underlying Ceuse (Disease or trijury thet Initieted events resulting in deeth) Last Division of Vital Records, P.O. Box 68760, attending physician for use es the buria Physician/Medicai Due to (or es e consequence of): Pert II. Other significant conditione contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contributa to the causa of death? 2 2000 1 Yes 3 Probably 4 Unknown signed þ Completed 24a. Was an eutopsy performed? 24b. Were autopsy tindings eveitable prior to completion of ceuse of death? this certificate 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case reterred to medicel examiner? Be 28. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 27. Menner of Deeth 28b. Time of 28d. Dascribe how injury occurred After 5 Pending invastigetion Naturet 2 D Accident nours efter death.

neral Director: A
filled in by the for 1 ☐ Yes 2 ☐ No 6 Could not ba 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours e To the Funeral Completely filled I 1gl Certifying Physician: To the best of my knowledge, death occurred et tha time, date end place, and due to the ceuse(s) and manner as steted.
2 Medical Examtnar: On the basis of examination end/or investigation, in my opinion, deeth occurred at tha time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifier 29b. Signature and title of certif 29c. Licansa number 29d. Data signed (Month, Day, Year) use ot deeth (Item 23e) (Type, Print) var

32. Registrer's Signature

DHMH 16 Rav 6/95

Registrar



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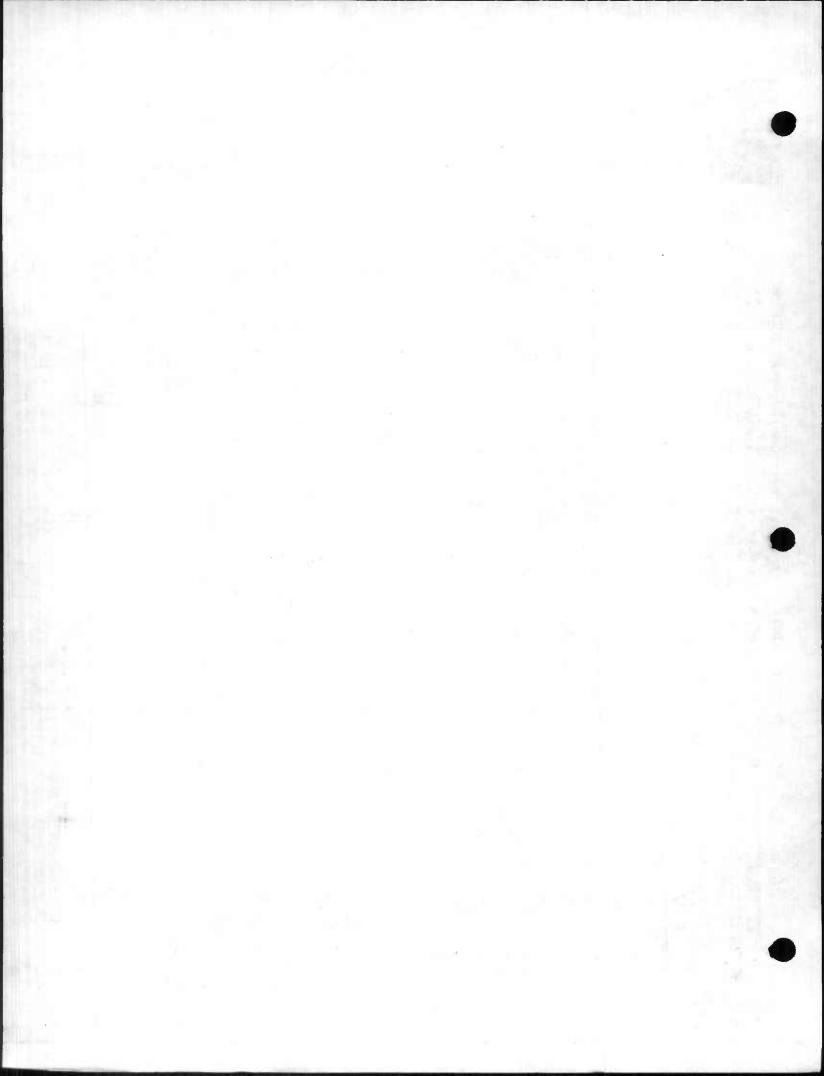
					,	C	ertifica	ate of	f Death	,	Reg. No.	/ La. (	0000
			1. Decedent's Name (First, Middle	e, Last)				,		2. Dete of De	eeth		3. Time of Deeth
100	Physic		PEARL HARTLOVE			SEPTEMBEL 15 1998			5:50 AM.				
	/Medi Examir		4e. Facility Neme (If not institution	, give street end num.	ber)				4b. City, Town, or	1 4 -	-		
14	Adiiii		MARINER HEALT	H CARE					CATONSV	TITE	RAT	TIMORE	a a
3 -	Funeral		5. Social Security Number		. Age (In yrs	s. last birthd		der 1 Yea	r If Under 24 Hr	s. 8 Date of Bi	rth		
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7000	or its	by Fur	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed Ford led 1  Yes 2 If Yes, Give Yeer or Det	2 No				ben, Mexican, Pue Specify:	rto Ricen, etc.)	Speci	ock, White, e	etc. WHITE
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lan a		To	CHARLES WILLIA	M SANDER					GRACE	VIRGINIA	MEYER		
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	es th ignex be d	by	- REN	TIL PA	LUIL	E				-			
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PE Division of Vital Records,	ysicien: The la is certificate he director, page	0	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	patient 2	☐ ER/Outpa	tient 3	DOA O	thos: -	Home 5 ☐ Res		her (Specify	)
ō	eral eral	n:T	27. Manner of Deeth	28a. Dete of		28b. Time	e of	28c. Inju			how injury occu		
Ö	offing th.	tio	1 Naturel 5 Pending		, Day Year)	Injur	M M		ork? ☐ Yes 2 ☐ No				
N. S.	Atter des	Certification:	3 ☐ Suicide 6 ☐ Coutd n	oot be ned 28e. Place o building	of tnjury - At I	home, farm,	street, fect	ory, office	9	28f. Location	(Street and Num	ber or Rural	Route Number,
Ö	or Original	ert	4 Homicide	building	g, etc. (Spec	cify)				City or To	wn, State)		
	To the Hospital or Attending Physicien: within 24 hours after death: To the Funeral Director: After this certifica completely lilled in by the funeral director,	edical 0	(Check only 2 Medical E	Physician: To the bearing: On the bes	is of examin	nowledge, de	eath occurre	ed et the t	time, date and pled	e, and due to the	ceuse(s) and m	enner as ste	ated. the ceuse(s)
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7/1	N V V		29b. Signature end titte of certifier	1.0			2	29c. Licer	nse number		29d. Date sign	ed (Month, E	ay, Year)
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			30. Name end eddress of person v RUBEN LEID  31. Dete filed (Month, Day, Year)	who completed cause	of deeth (tte	em 23a) (Typ	pe, Print)						M 0
1			RUBEN REID	ER M.O.	74	45	FURN	ACE	BRANC	H Rd	Gen Bu	unie.	11d 21060
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	Certificate of Dea	th Reg. No.							
Discoult in the second	Decedent's Nama (First, Middla, Last)	2. Data of Death Month Day Year  3. Time of Death							
Physician /Medical	BARBARA ELAINE HINES	September 13,1998 211							
Examiner									
	St. Agnes Hospital B 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Yaar   If Ur	altimore N/A nder 24 Hrs. 8. Data of Birth 9. Birthplace (Stata or Fore							
Funeral Director	220-38-8975 1 M 2 F 56 Yrs. Months Days Hou								
2 .	Usual Rasidance of Decedant  10a. Stata 10b. County 10c. City, Town or Location	sod topide City Lim							
aho aho		10d. Inside City Lim 1√2 Yes 2 □1							
vith the Mar	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?							
after death with the Marylar or Items 23s or 28s-f show mine must be notified.									
offer death v	11. Marital Status 12. Was Decedant Evar in U.S. 13. Was Decedent of Hispanic If Yas, specify Cuban, Max	c Origin? (Specify Yes or No- dican, Puarto Rican, atc.)  14. Race - American Indian, Black, Whita, atc.							
20 2 3	3 ☐ Wildowed 4 ☐ Divorced Year or Datas:								
1 21215-002 ed within 72 hours vyjene. er than "natural", ut the find on East	15. Decedant's Education (Specify only highast grada completed) (Give kind of work done during life. DO NOT use retired)	most of working 16b. Kind of Business/Industry							
2121 d within jiene. r then the M	Elementary/Secondary (0-12) Collega (1-4or 5+)								
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and be filed and land land land land land land land		ELAINE B. WARD							
Maryland 2 nd 2 should be filed alth and Mental Hygic 27 is marked other r traumatic event, To Re Cr		umber or Rural Route Number, City or Town, State, Zip Code)							
Tand 2 Heelth as man 27 is wither train		OREST RD COLUMBIA, MD21045							
	20a. Method of Disposition  1  Burial 2 Cramation 3 Removal from Stata 4 Donation 5 Other (Specify)	Data 20c. Location - City or Town, State 9-19-98 BALTO, MD							
Baltimo pemil. Pages Department of Important: If it sny Injury or once.		acilityBETTS FUNERAL HOME							
Balti Permit. Departm Importa sny loju	1129 N. CA								
	23a. Part1. Entar tha disaasa, or complications that causad tha death. Do not antar tha mode of dying, such shock, or heart failure. List only one ceuse on each line.								
Physician	shock, or haart failura. List only ona cousa on each line.	Interval Between Onset and Death							
/Medical	Immediata Causa (Final disaasa or condition Acute myocardial infarc								
Examiner	disaasa or condition rasulting in death)  Acute myocardial infarc	tion minutes							
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68760, licete passecuted physician and stree buttertransit at the buttertransit edical Examiner	Sequentially list conditions,  Due to (or as a consequence of):								
00 10 1	Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events  Due to (or as a consequence of):  Due to (or as a consequence of):								
ficete pass physician is the built	that initiated events rasulting in death) Last Due to (or as a consequence of):								
P.O. Box 687  tet the death certificate at by the attending physe etached for use as the Physician/Medic		1							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P								
E & D .	Hypertension, cerebral vascular accident	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unkn							
cords, P.O w requires that the been signed by th should be detache	[시발][[Head of the control of the co	24a. Was an autopsy 24b. Wara autopsy tinding							
Record le law require		performed? available prior to completion of cause of death?							
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Vital Inclen: The certificate rector, pag		Place of Death (Check only one)							
Of Vita Physician: This carlificant director,		rsing Homa 5 Residence 6 Other (Specify)							
g Physer this neral d		28d. Describe how injury occurred							
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Division of attending P as often death.  The division of the the three of three of three of the	3 ☐ Suicida 4 ☐ Homicida 6 ☐ Could not be determined 28a. Plece of Injury - At homa, tarm, street, factory, office building, etc. (Specify)	28t. Location (Street and Number or Rural Routa Number, City or Town, Stata)							
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he Hospi in 24 hou he Funer pletely fill edical	29a. Certifier (Check only  Check only  (Check o	a and place, and dua to tha cause(s) and manner as stated. deeth occurred at the time, date and place, and due to the cause(s)							
Division of Vita To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be	one) and manner stated.  29b. Signature and title of certitier 29c. License numl	per 29d Date signed (Month, Day, Year)							
T X P S	D43453								
	Africa for Mark	9/19/78							
V	30. Nama and address of person who complated course of death/filem 23a) Type, Print)	21229							
-04-4	31. Data tiled (Month, Day, Year) 32. Registrarts Signatura	e - 900 Caton Ave. Balto, M							
State Registrar	have the same of the same of								
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DHMH 16 Rev 6/95



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedant's Nama (First, Middla, Last) September 16, 1998 Wiliam Joseph Hofmann, Sr. 10:00 AM 4a Fecility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death My Second Home , 3611 Mary Avenue Baltimore If Undar 24 Hrs. Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) If Undar 1 Yaar Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Dey, Year) Months Days XXM 2DF 214-03-1697 Sept. 1, 1919 Maryland Usual Rasidanca of Decedant 10d. Insida City Limits 10c. City, Town or Location 10a Stata 10h County 1XXYas 2 No Baltimore Maryland N/A 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21206 USA 3611 Mary Avenue My Second Home 12. Was Decadant Evar in U,S. Amped Forcas? 10 Ayas 2 □ No If Yas, Giva Yaar or Datas: WW ∏ Was Dacedant of Hispanic Orlgin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Race - Amarican Indian 11. Marital Status Black, Whita, atc. 1 Navar Marriad 2 Married 1 Yas 2XXNo Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15 Decedent's Education (Specify only highast grada complated) Elementery/Secondery (0-12) College (1-4or 5+) Electrical Work Machinist Foreman 9 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Treva C. Harris Arthur J. Hofmann 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Elizabeth Hofmann Wife 3939 Roland Avenue, APT 611 Baltimore, Md 21211 20b. Place of Disposition (Nama of camatary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Buriai 2/Carmation 3 ☐ Ramoval from Stata 4 Donation Othar (Specify) Hilltop Service Corp. 9/17 Towson, Maryland 22. Nama and Addrass of Facility eral Service License Burgee-Henss Funeral Home PA 23a. Part. Ent. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest. 23a. Part. Ent. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest. Approximete Intervel Between Onsat and Death Immediata Causa (Final disaasa or conditio resulting in death) ementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated avants resulting in death) Last Due to (or es a consequence of) Dua to (or as a consequanca of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Decebetue Welle 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy performed? comptation of causa of death? 1 Yas 2 No 1 Tyas 2 No 25. Wes casa raferred to medical 26. Placa of Daath (Chack only ona) Othar: 4 Nursing Homa 5 nesidence 6 Othar (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatiant 3 ☐ DOA 28e. Date of Injury (Month, Day Yaar) 28c. Injury at Work? 27. Mannar of Death 28b. Tima of 28d. Dascribe how Injury occurred 5 Panding 1 Maturei 2 C Accident

Examiner burtal-transit pue Division of Vital Records, P.O. page 2 cartificata this

**Physician** 

/Medical

Examiner

Directo

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**Funeral** 

Director

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Hygiene.

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Department of important: If any injury or

**Physician** /Medical

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filed within 72 hours after

altimore, Maryland 21215-0020

Physician/Medicai à Completed Be 0 Certification:

Hospital or Attending Physician: funeral director. After s efter deeth. 24 hours e Funeral [ To the F within 2

Registrar

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1 ☐ Yas 2 ☐ No invastigation 6 Could not be datarmined 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straet, factory, offica building, atc. (Specify) 4 Homicida Certifying Physician: To tha best of my knowledga, death occurred et tha tima, data and place, and dua to tha causa(s) and mannar es steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the ceuse(s) and manner stated.

29b. Signatura and titla of certifiar Uberal 29c. Licansa number D26748 29d. Data signad (Month, Day, Year) 9/16/98

30, Nama and address of person who complated causa of daath (Itam 23a) (Type, Print) Auel Uperal 4419,

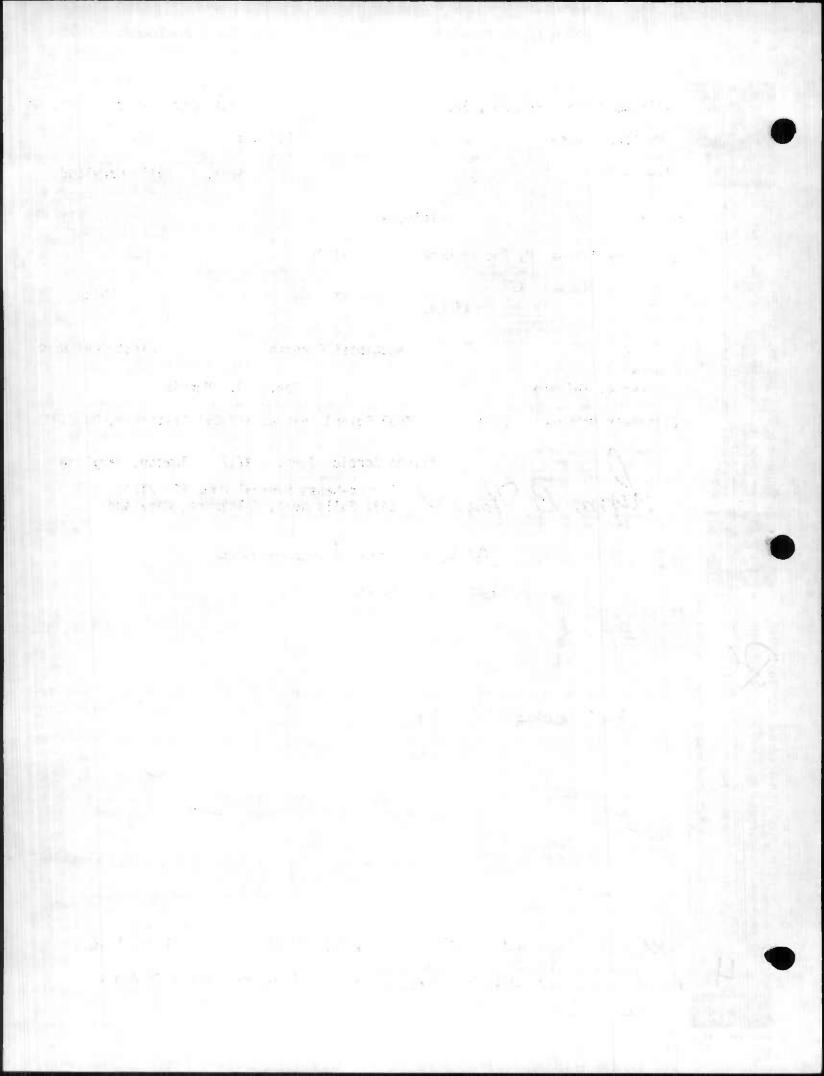
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3 Suicide

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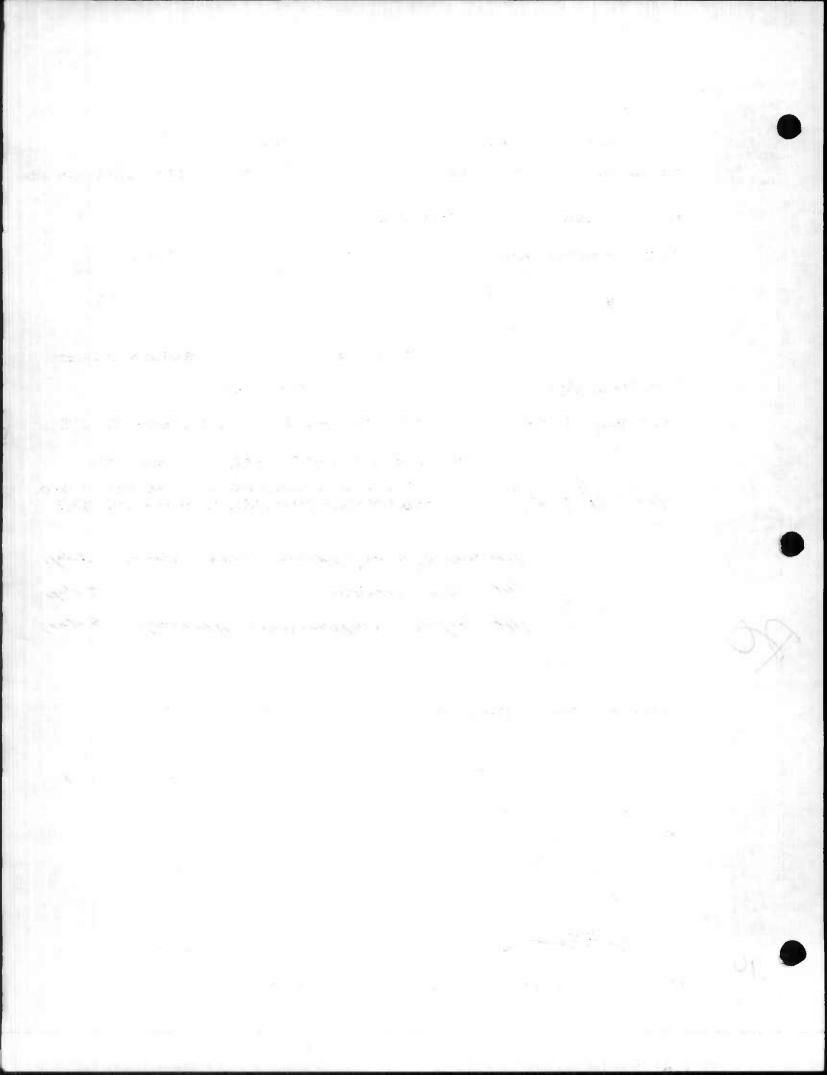
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FALLS 32. Registrar's Signature Darks



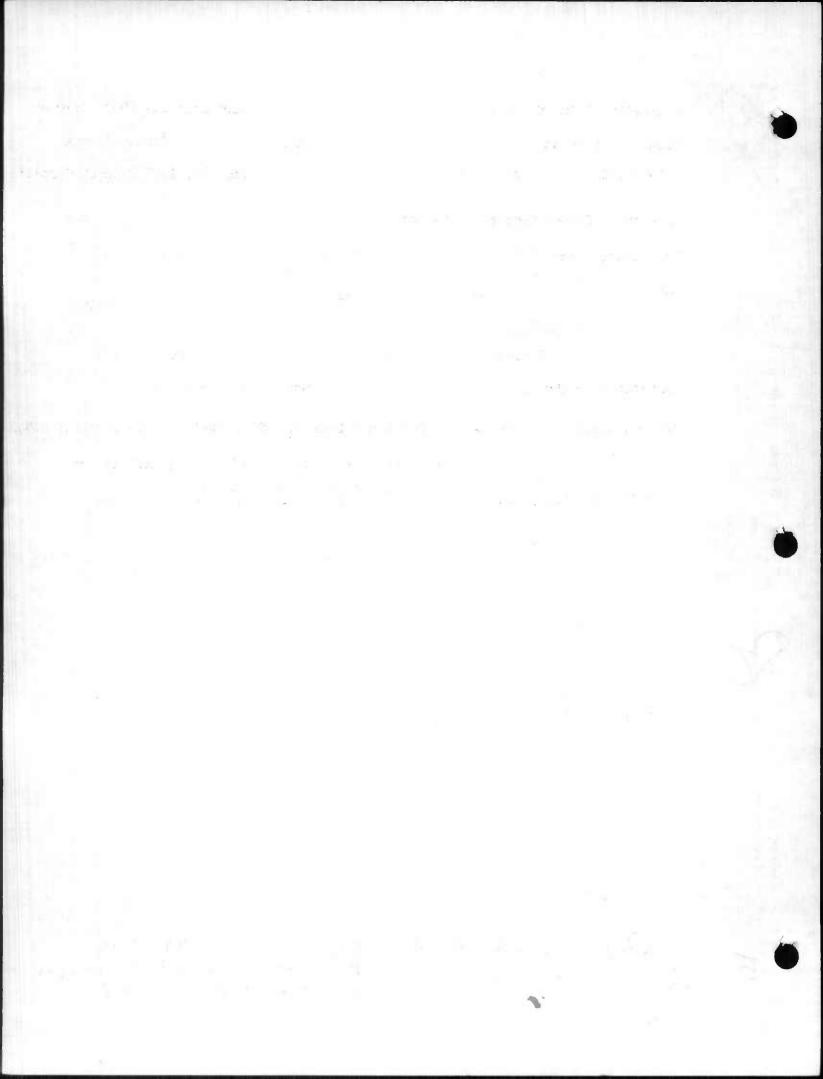
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Physici-		JANUS	3			HIG	₽H		Month	Day	Year 1000	13:14 P
/Medic		4a. Fecility Name (If	not institution, g	ive street and nur	mber)	111.0	711	4b. City, Town, or L			y of Death	113:14 P
LAdiiiii	161	THE JOH	INS HOPK	INS HOSP	PTTAL.			BALTIMORE			N/a	
Funeral		5. Social Security Nu				s. last birthday	) If Under 1 Yea	if Under 24 Hrs.	8. Date of Bir (Month, Da			place (State or For
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show at at		10e. State	10b. County		10c. C	City, Town or L	ocation				1	Od. Inside City Li
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r 28	Director	10e. Street and Num	ber				10f. Zip Code			10g. Citizen of	What Cour	ntry?
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E TR	Funeral	11. Marital Status		12. Wes Dece Armed Fo	edent Ever in	U,S. 13	. Was Decedent of	Hispanic Orlgin? (Sp	ecity Yes or No	- 14. Ra	ce - Americ	
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	Pe		15. Decedent's E	ducetion		16a. Dec	edent's Usual Occi	upation		16b. Kind of B	Business/In	dustry
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s mar	-	19a. Informant's Nar				19b. Mal	ling Address (Stree	et end Number or Rui			n, State, Zip	Code)
7 5		Mary Hi	igh / Mo	ther		1900	O Thames	St., Apt.	323. P	altimor	P. M	1. 21231
20		20a. Method of Dispo	osition			Place of Disc	position (Name of ematory or other pi		Date	20c. Location		
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Important: any injury once.		21. Signeture of Fun		**	Dell		22. Name end Add		cory	Laur	el, N	10.
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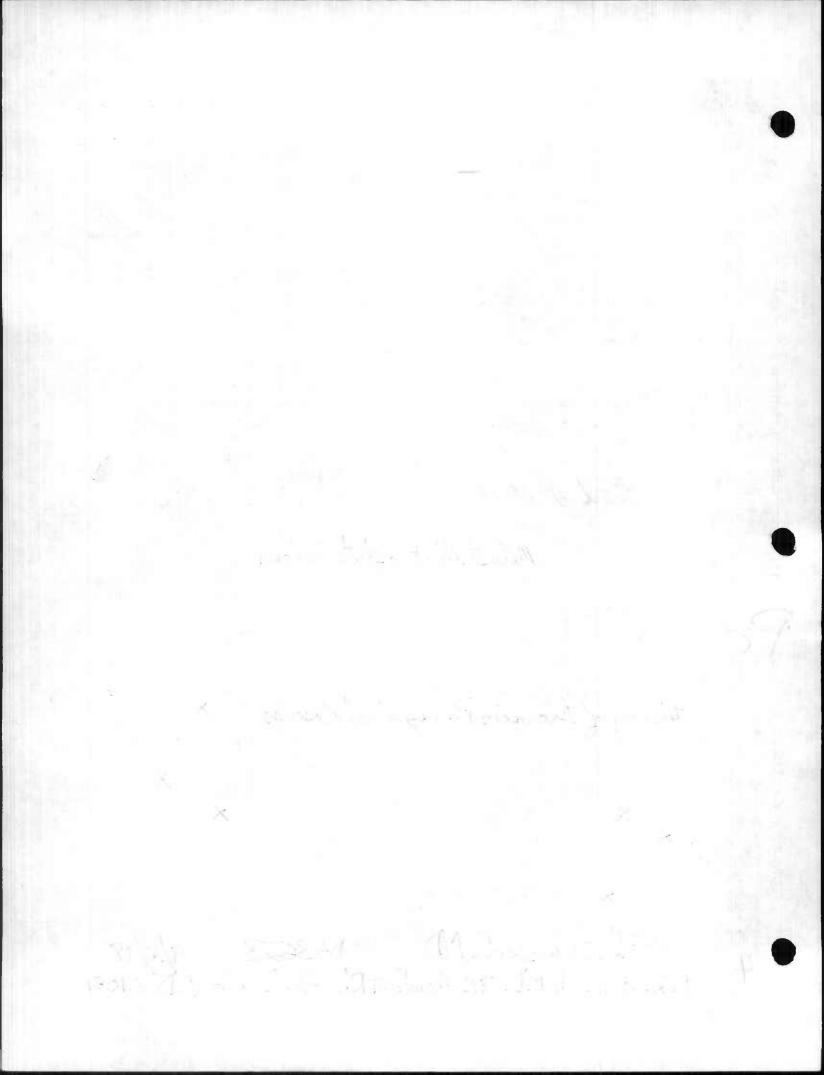
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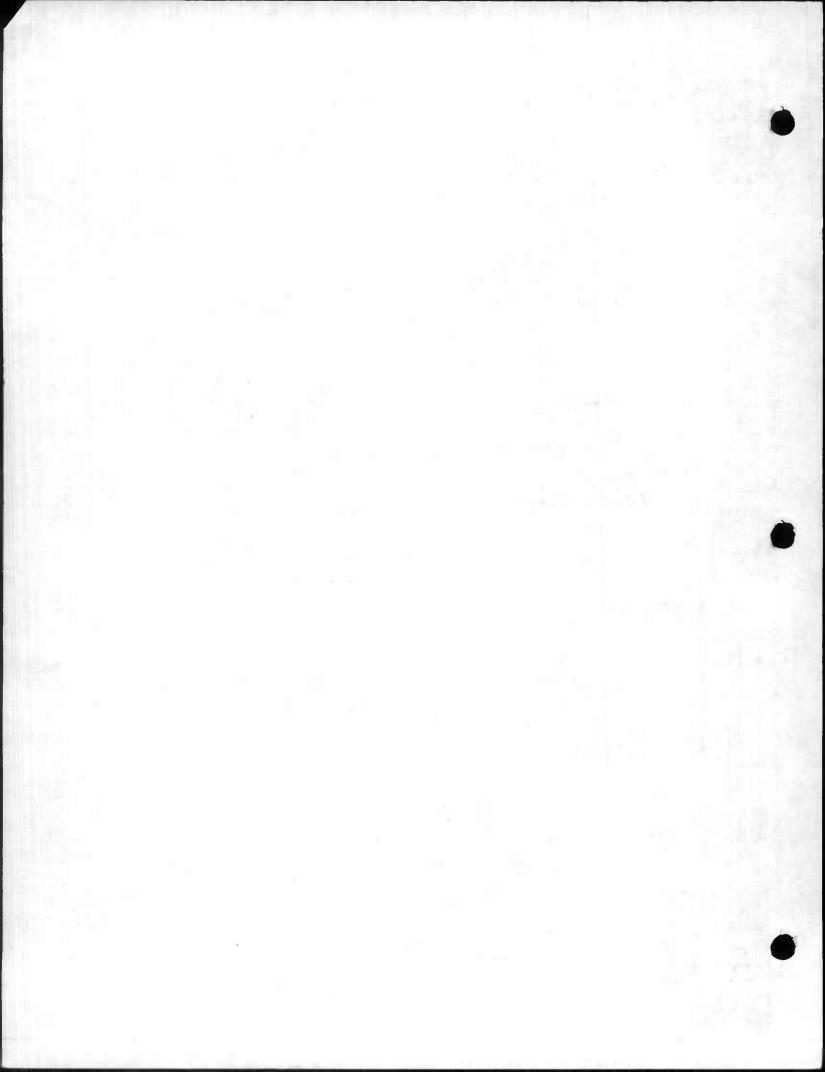


State of Maryland / Department of Health and Mental Hygiene Amend: #7 Per FH Film G763 9-18-98RC Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death September 14, Year 1998 **Physician** Tommy E. Harrison 6:55 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1406 Harvey Avenue Severn Anne Arundel If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days MM 2DF Months Hours 62 Director 417-42-8002 Dec. 31,1935 **Alabama** Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or frame 23a or 28a-f ahow MD 1 Yes ZONo Anne Arundel Director Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1406 Harvey Avenue 21144 USA Funeral 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 XMarried 21215-0020 1 Yes 2 No Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ith and Mental Hygiane. 27 Is marked other than ": r traumatic avant, the Men filed within Elementary/Secondary (0-12) College (1-4or 5+) Production Operator **NEVAMAR** Baltimore, Maryland 17 Father's Name (First Middle Last) 18. Mother's Nama (First, Middle, Maiden Sumama) . Peges 1 and 2 should be filt iment of Heelth and Mental H. lant: if Itam 27 Ia marked oth jury or other traumatic avan 8 Claude Harrison Ada Whitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Virginia L. Harrison-Wife 1406 Harvey Avenue, Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Important: If any Injury or pose. 9/18/98 4 Donation 5 Other (Specify) Metro Crematory Baltimore, MD 21. Signature of Funeral/Servide Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. Arrelo 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box.687 Due to (or as a consequence of): been signed by the attending p should be detached for use as P.O. Part It. Other significant conpontributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? DAGA 2 1 Yes 1 ☐ Yes 2 ☐ No certificata Division of Vital Attanding Physician: Be 25. Was casa refarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 □Other (Specify) Certification: To 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Aftar 1 Natural 5 Pending 1 Yes 2 No 24 hours after death. investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ò Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier edical within 24 ho To the Fune completely f (Check only one) \$ 29c. License number 29d. Date signed (Month, Day, Year) n 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Sign State 1 8 1998 Registrar SEP



State of Maryland / Department of Health and Mental Hygiene Item: 1 per M.D G-763 9/18/98 reb Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last), ARTHUR JEFFRIES 2. Date of Death 3. Time of Death Month Day **Physician** 46PM 1998 4b. City, Town, or Location of Death 4c. ( /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE 1-050 martin If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) MAY 10, 1910 Birthplace (State or Foreign Country)
 VA 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours ₩ 2 F 88 Yrs 216-05-7767 Director Usual Residence of Decedent death with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d Inside City Limits tem 27 is marked other than "natural", or flems 23s or 28s-f show other traumetic event, the Medical Examinar must be notified at N/A MD BALTO 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1247 WOODBOURNE AVE 21239 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Nen any Injury or other traumatic event, the Hedical Egamman 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 N Widowed 4 □ Divorced Yeer or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) STEEL CO N/A 2nd LABORER 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JAMES JEFFRIES MARY COSBY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Neme/Reletionship (Type, Print) BARBARA JOHNSTON 1247 WOODBOURNE AVE BALTO, MD 21239 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 Burial 2 Cremetion 3 Removel Irom Stete ARBUTUS MEM PK 9-21-98 BALTO, MD 4 Donetion 5 Other (Specify) 22. Name and Address of Facility BETTS FUNERAL HOME 21. Signeture of Juneral Service Licensee 1129 N. CAROLINE ST BALTO, MD 21213 Belly africia 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examine Due to (or as e cons Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequênce of): Box 68760 Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 書 signed by t 1 Yee 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? 2 No 1 Yes 2 No 1 Yes 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient 200 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Althor 1 Neturel 2 ☐ Accident Attending 5 Pending death. 1 Yes 2 No To the Hospital or Attendition within 24 hours after death.
To the Funeral Director: A completely filled in by the fu Investigation 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical 29s. Certifier Maching Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) no 30. Name and address s of person who completed cause of death (Item 23a) (Type, Print) 95 31. Date filed (Month, Dey, Year) 12 11 ark 32. Registrer's Signeture State 1 8 1998 Baper SEP Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Item#5,22 per FH G764 10/20/98 EW 3. Time of Death 2. Date of Death 1. Decedent'a Name (First, Middle, Last) MORRIS TONES SEPTEMBER 8, 1998 14:46 PM 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY N/A 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 0884 Birthplace (State or Foreign Country) 1)ØM 2□ F 1960 220-64-0088 14, MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ty Yes 2 No N/A BALTO 10g. Cifizen of What Country? 10e. Street and Number 10f. Zip Code 2001 CLIFTWOOD AVE U . S . A . 14. Race - American Indian, Black, White, etc. 21213 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yas XIXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify:BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) OPERATOR COMPUTER CO 12th COMPUTER 17. Fathar's Nama (First, Middla, Last) MORRIS JONES SR MARY STITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY JONES 2001 CLIFTWOOD AVE BALTO, MD 21213 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) BALTIMORE CEM 9-12-98 BALTO , MD 4 Donation 22. Name and Address of Facility BETTS FUNERAL HOME CAROLIEN ST BALTO, MD 21213 1129 N. raa Caroline 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBRAL EDEMA 1 WEEK Due to (or as a consequence of): CRYPTOCOCCAI VEARS DISEASE RETROVIRAL 23b. Did tobacco use contribute to the cause of death? Part II. Other elanificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings available prior to completion of causa of deeth? 24e. Was en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No 26. Place of Death (Check only one)

**Physician** /Medical Examiner

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signed by the a

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this funeral

al or Attending P s after death. Il Director: After I ed in by the funeri

To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by

Division of Vital Records, P.O. Box 68760,

Physiclan/Medical Examiner

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Certification:

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permit. Pages 1 and 2 should be the Department of Health and Mantal Hyg Important if Nem 27 is married other any Injury or other traumented other any Injury or other traumented other

Baltimore, Maryland 21215-0020

Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

25. Was cese referred to medicel axaminar? 1 Yes 2 No 27 Manner of Death

Hospital: 1 Inpatiant 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

1 Natural 2 Accident 5 Pending investigation 6 Could not be determined 3 ☐ Suicide 4 Homicide

1 TYes 2 □ No Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

mo

(Check only one) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a. Certifier

12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

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29c. License number RES - 000

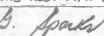
SEPTEMBER 8,1998

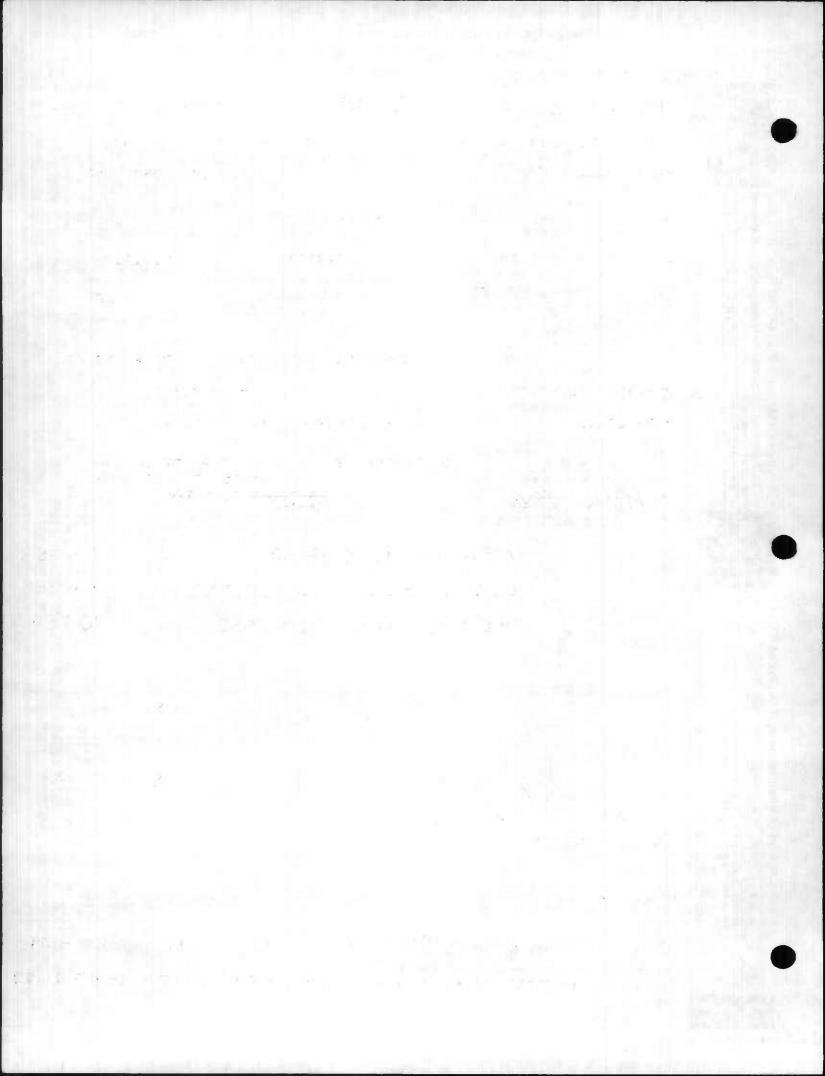
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

JOHNS HOPKINS HOSPITAL, 110 TOWER, BALTIMORE, MD 21287 JAMES M SIZEMORE

Registrar

32. Registrar's Signature





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Daeth 3. Time of Deeth ELSIEC. JUNES 4e. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Baltimore LORIEN FRANKFORD Nursing If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)
TINE 17, 1 5. Social Security Number 7. Age (In yrs. lest biffnday) Birthplace (State or Foreign Country) 1 M 25√F 80 216-22-3713 JUNE 17,1918 MD Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A BALTO 1 X Yas 2 No 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? 1703 ELLSWORTH AVE 21213 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puarto Rican, etc.) 14. Rece - Amarlcan Indian, Bleck, White, etc. 1 Never Marriad 2 Married 1 Yes 2 No If Yes, Give Yeer or Detes: 1□ Yes 2□No Specify: BLACK 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest greda completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) N/A Elementary/Secondary (0-12) DOMESTIC WORKER DOMESTIC 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) WALTER STRAWDER ISBELLE GETTINGS 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) CARL STRAWDER 1503 N. WOLFE ST BALTO, MD21213 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removal from State BALTIMORE CEM 9-18-98 BALTO, MD 4 ☐ Donation 8 ☐ Other (Specify) 21. Signature of Furnital Sarvice Licensee 22. Name end Address of Facility BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO MD 21213 23a. Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Batween Onset end Deeth Cerebellar Bleed Immediate Cause (Final one disease or condition resulting in death) week Due to (or es e consequence of) Sequentially list conditions, if any, laading to Immadiate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1) emention 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 14 pertension 24b. Were autopsy findings aveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Congestive Heart- Failure 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 28. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | EP/Outpetient 3 | DOA | Other: 4 | Mursing Home 5 | Residence 8 | Other (Specify) 1 Yes 2 No 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred 1 DNaturel 5 Pending

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

MD

8th

**Funeral** 

**Director** 

ral', or items 23a or 28a-f show Examiner must be notified at

"natural", or

permit. Pages 1 end 2 should be filed within Department of Health end Mental hygiene. Important: If Item 27 is marked other than "reany Injury or other traumatic event, the Med

Director

Funeral

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Completed

with the Maryland

72 hours efter

Baltimore, Maryland 21215-0020

P.O.

I or Attending Physician: The law requires that the effer death.

Director: After this certificate has been signed by th of Vital Records. Division filled in by the • Funeral I Hospital To the within 2 To the

Physician/Medical Completed by Be Certification: To

State Registrar

Medical

1 Cortifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and menner steted. 29e. Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

29b. Signeture end title of certifier

investigation

6 Could not be determined

29c. Licansa number D43725

1 Tyes 2 No

29d. Date signed (Month, Day, Yaar)

Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

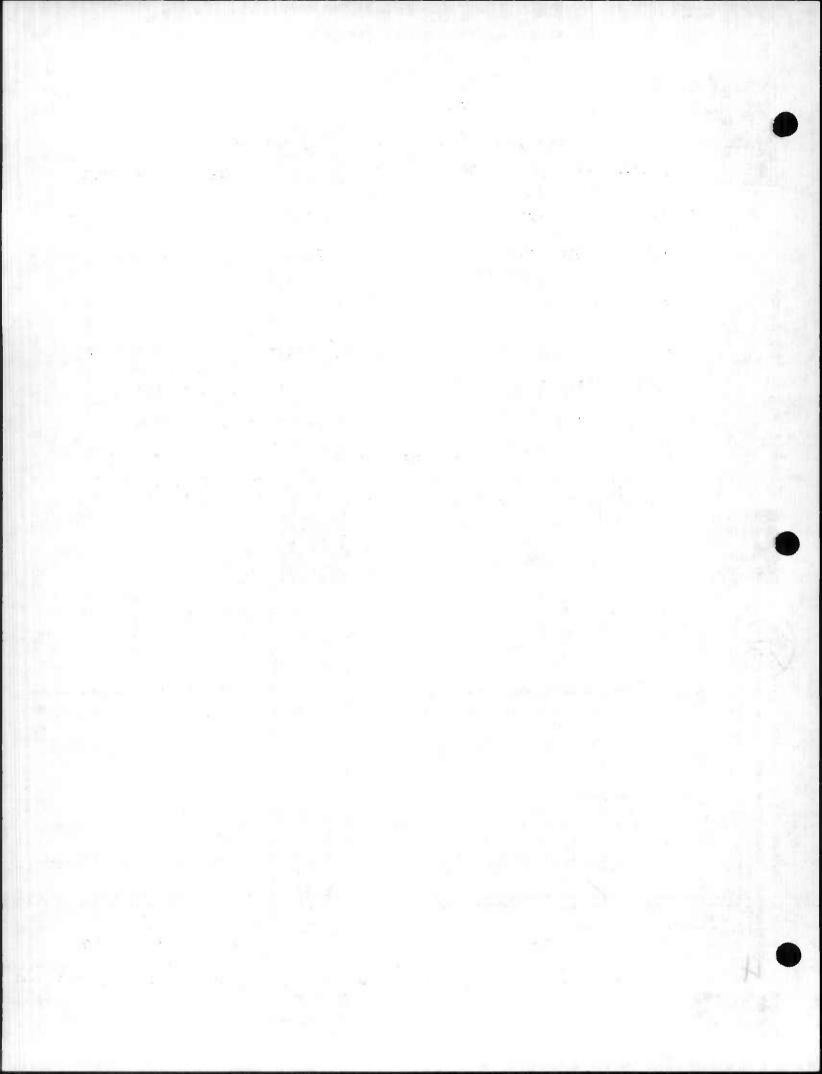
MAITMOUD MD

31. Date filed (Month, Day, Yeer)



28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify)

821 N. Entan St Baltimore MD 260

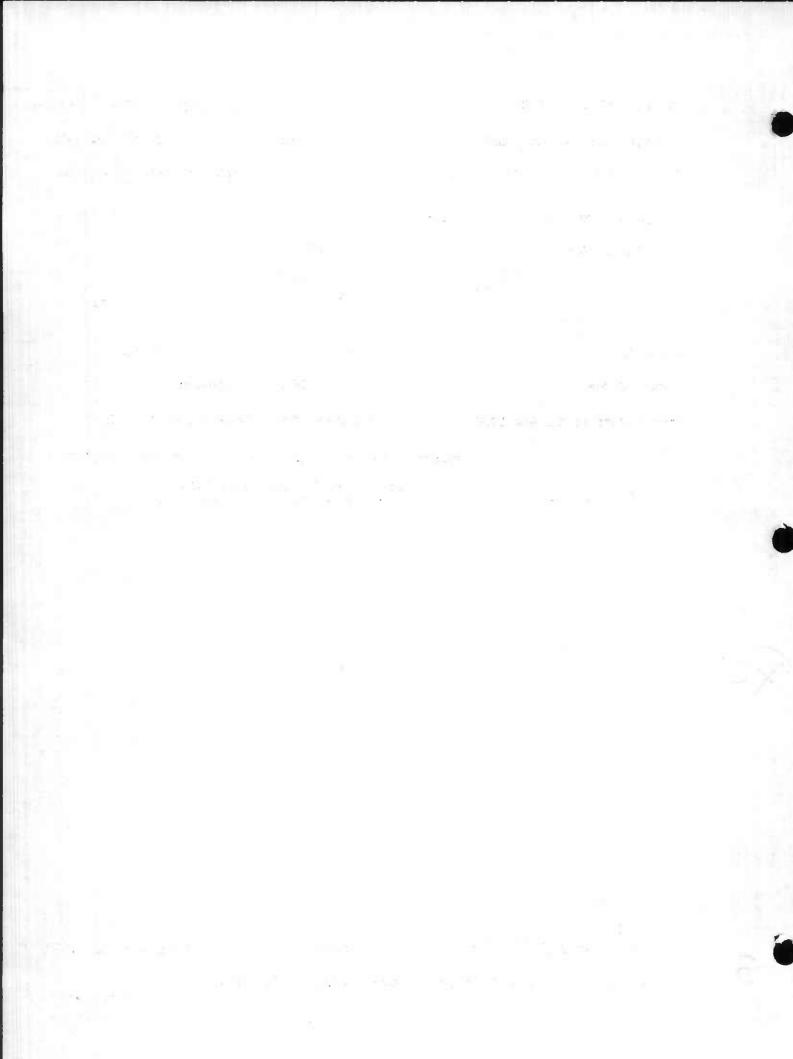


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death September 16, 1998 **Physician** MAZIE LILLIAN JESS 1:55 am /Medical 4a. Facility Nama (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Laurel Regional Hospital Laurel | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day Y March 29 5. Social Security Number 7. Aga (In yrs. last birthdey) 9. Birthpiace (Stete or Foreign **Funeral** 1 M Maryland **Yrs** Director 213-22-1603 92 7906 Usual Residence of Decedent with the Merylend 10a State 10b County 10c. City, Town or Location 10d. tnside City Limits 7 is marked other than "natural", or flems 23s or 28s-f show treumstic event, the Medical Examiner must be notified at XX Yes 2 No Director Prince George Laurel Maryland 10e. Street and Numbar 10f. Zip Code 10g. Citizen of What Country? 9001 Cherry Lane 20707 USA deeth Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Yaar or Dates: 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Peges 1 end 2 should be filed within 72 hours efter c Department of Health and Mental Hygiene. Important: if item 27 is marked other tran "natural" or iten any injury or other treumatic event, the Medical Evant was back. 1 Nevar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: þ Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grade 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Sumame) Be Edward Cross Tda unknown ပ 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Child HC 62 Box 109E Great Cacapon, W. Va. Donald Jess 20a. Method of Disposition

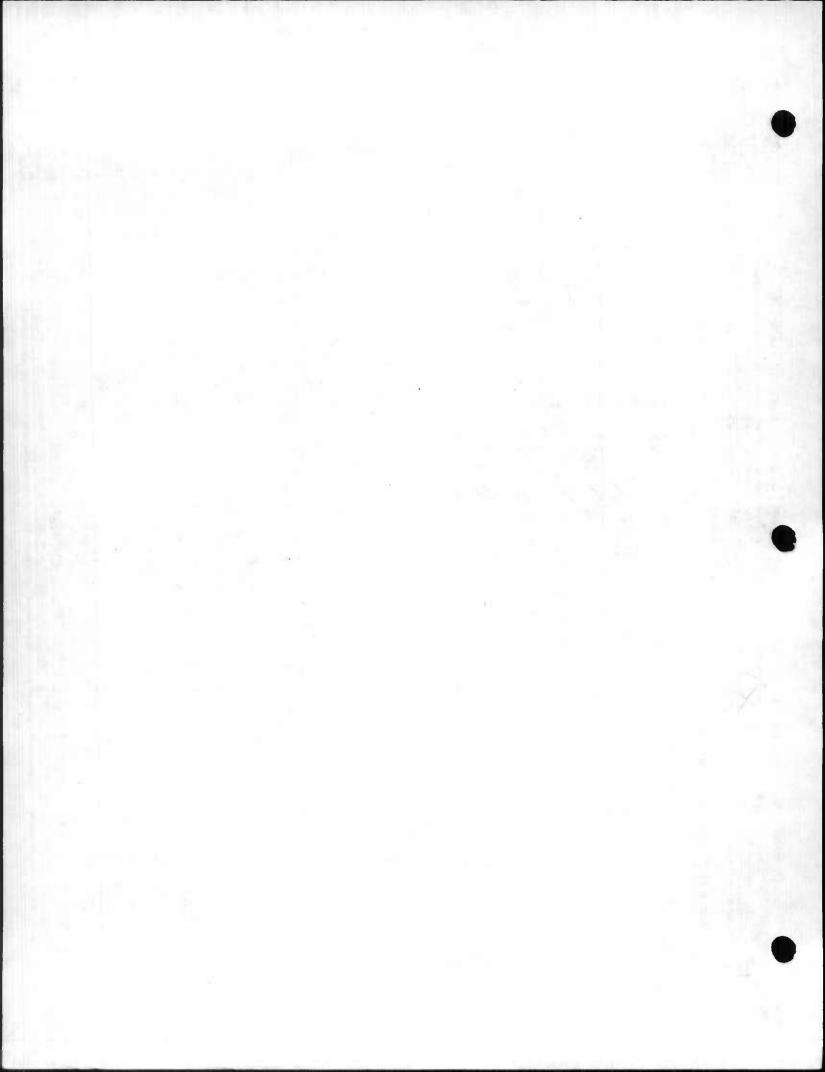
1 ☐ Buriai 2 ☐ Cramation 3 ☐ Removal from State 20b. Place of Disposition (Neme of cematary, cremetory or other place) 20c. Location - City or Town, State 9/18/98 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park Dorsey, Maryland 22. Name and Addrasa of Facility 21. Signature of Funeral Service Licenses Donaldson Funeral Home, P.A. Con 313 Talbott Avenue Laurel, Maryland 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate interval Betw Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition resulting in death) Aspiration Pneumonia Hours Examiner Due to (or as a consequence of): Examiner ician and buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Box 68760, physician Physician/Medical Dua to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, P.O. E 3 Probably 4 Unknown 1 □ Yee 2 No signed i à 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed peed hes page 2 1 Yes 2XXV 1 ☐ Yes XX No certificate Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical 25. Was cese referred to medicei examiner? Be 28. Place of Death (Check only one) Hospitai: Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 1 Yes XX No 2 ER/Outpatient 3 DOA 1 Appatiant funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of injury (Month, Day Year) 28b. Time of 28c. injury et Work? Certification: 5 Pending investigation 1XX Natural 1 ☐ Yes 2 ☐ No 2 Accident 8 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) filled in by 4 I Homicide \*\*Cortifying Physician: To the best of my knowledge, death occurred at the time, data and piace, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piace, and due to the cause(s) and manner stated. 29a. Certifier To the To the To the I 29b. Signature and title of certifier 29c. Licensa number 29d. Data aigned (Month, Day, Year) D43260 September 16, 1998 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 13952 Baltimore Avenue 20707 Laurel, Md. Jenny Y. Moy 31. Date filed (Month, Day, Year) SEP 181998 32. Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Neme (First, Middle,	Last)	Ocial	ficate of	Dealli	2. Date of Dea		3. Ti	ima of Death
Physician	The second secon	IORMAN	JORDE	EN		Month SEPT.	Dey 15,19	Year 9:	37pm
/Medical Examiner	4e Facility Nema (If not institution,	give street and number)			4b. City, Town, o	or Location of Death	4c. County		
	CROFTON CONV	. CENTER			CROFTO	N	ANNE	ARUNDE	L
Funeral	5. Social Security Number 220-05-8108	Sex 7. Age	M. J.O. Last Diratolay/	f Under 1 Year fonths Days	If Under 24 H Hours Mi			9. Birthplace (S Country)	
Director	Usual Residence of Decedent	2121	78 Yrs.			SEPT 7	,1920	ODENTO	N MD.
P	10a. State 10b. County		10c. City, Town or Locati	ion				10d. lns	ide City Limits
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ura after ur, or the monos by Fur	11. Marital Status  1 Never Merried 2 Marrier  3 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forces? 1 Yes 2 Who If Yes, Give Year or Dates:		s Decedent of Hes, specify Cub		(Specify Yes or No- erto Rican, etc.)		e - American Indi k, White, etc. WHITE	
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should in Men marke	19e. Informent's Name/Reletionship					Rural Route Number			
2 2 2 2	MARIE L. JORD			- 1. / 11 - 1 - 11 / -		GAMBRIL			
ges 1 and 2 should be file, in of Health and Mental Hy, if fleen 27 is marked other or other treumatic event,	20a. Method of Disposition		20b. Place of Disposition	on (Name of				City or Town, Ste	ete
Definition of permit. Pages 1 and Department of Health Important: if Item 27 any injury or other tiping.	Burial 2 Cremetion 3 4 Donetion 5 Other (Spe		LAKEMONT			9-18-98	DAVII	SONVII	TE MD
Demit. Pa Departmen Important: any Injury	21. Signature of Funeral Service Lie		22. N	ame end Addre	ess of Fecility			DOMVII	122 112
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	23a. Pert1. Enter the disease, or co shock, or heart failure. List or	emplications that caused the	ne death. Do not enter the	he mode of dyi	POLIS ng, such es card	RD GAMBR	ILLS_Nest,	Appro	ximete
Physician	shock, or heart failure. List or	ly one cause on each line							el Between and Death
/Medical	Immediate Cause (Finet disease or condition	· Metas	total Luna	Carro	nema			13 11	and It.
Examiner	resulting in death)		ue to (or as a consequer		MI TYLOL	100		011	NV N WO
axecuted in end tel-transit Examiner	A TOTAL S								
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certificate hi irector, page	25. Was case referred to medical axaminer?				26. Place of D	eath (Check only or	16)	1	
\$ 50 D	1 ☐ Yes 2 ☐ No			3LI DOV		Home 5 ☐ Reside	ence 6 Othe	er (Specify)	
al or Attending Phase deed death.  In Director: After the din by the funeral Certification:	27. Manner of Death  1 SNatural 5 Pending	28a. Date of Injury (Month, Day		28c. Inju Wo M 1 □	ryat rk?  Yes 2 □ No	28d. Describe h	ow injury occurr	red	
then death death y the	2 Accident investigat 3 Suicide 6 Could no	be no Dissertistics	/ - At home, farm, street,		1163 20160	28f. Location (S	treet and Numb	er or Bural Boute	Number
or Attending effer death. Director: Affer In by the fune ertification	4 ☐ Homicide determine	building, etc.		, ractory, onice		City or Town	n, Stete)	er or Hurar House	a rvuiniber,
To the Hospital or Attending Physician To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one)  1 Certifying 2 Medical Ex	Physician: To the best of a aminer: On the basis of e and manner state	xamination and/or invest	curred et the til	me, date and pla opinion, deeth oc	ce, end due to the courred at the time, d	ause(s) end ma ate and place, i	nner es stated. and due to the ca	iuse(s)
2520	29b. Signature and title of gertifier	and mainted state		29c. Licens	se number	2	9d. Date signed	d (Month, Day, Y	ear)
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with To the Common	Man.	1411		J 700 .	778		11 1 1 1 4	18	
To some with the sound of the s	30. Name and address of person with	n completed cause of de-	th (Hern 23a) (Time Bi-		158		1/1/1	*	
Jo with word of the second of	30. Name and address of person wh	o completed cause of dea	th (Item 23a) (Type, Prin	nt)		106 , od	enter	M22111	3



۸۳	ond: #10	£ 10		State of M	aryland / l		of	k. Assure Al Health and M f Death	fental Hyg	iene		28641
Am	end: #10	T, 15	Per Anatomy BoARD Film G763 9-18-93RC CENTRICATE OF DEATH  Decedent's Neme (First, Middle, Last)				Dealii	Reg. No.			3. Time of Deeth	
	Physic		Donna Lee Ca		bs				Septemb	Day.	198	12:09 AM
	/Medi		4e. Fecility Neme (If not institution, give				— j	4b. City, Town, or Lo		4c. Count		12.01/1110
	Exami	ner	Washington Cou					Hagerstow			shingt	on
	Funeral		5. Sociel Security Number 6. 9	Sex 7. As	ge (In yrs. lest bii	thdey) If Under 1		If Under 24 Hrs.	8. Dete of Birth			lece (State or Foreign
	Director		230-48-9309 Usual Residence of Decedent	1□ M 2□xF	58	Yrs. Months	Deys	s Hours Min.	(Month, Day, May 15,		D.C.	fry)
ee	Marylan a-f show iffed at	ctor	10e. Stete   10b. County     Maryland   Washing	gton	10c. City, Tow Hager	n or Location Stown					10	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
M	h with the N 23e or 25e-1 at be notifi	al Director	10e. Street end Number 11 West Baltimor	e Street		10f. Zip (		21740	10	0g. Citizen of		try?
heobs, Donnalee	urs after death with the Maryla af, or items 23e or 28e-f sho Examiner must be notified at	by Funeral	11. Maritel Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 [X] If Yes, Give Yeer or Detes:				Hispenic Orlgin? (Spetban, Mexican, Puerto o Specify:	ecify Yes or No- Rican, etc.)	14. Rai	ce - America ck, White, e	etc.
21215-0	within 72 ho fone. Then "natur the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondery (0-12)	ducetion ede completed) College (1-4or		Decedent's Usual (Give kind of work life. DO NOT use Clerk Ty	done	e during most of work red)	ing	Unkno		lustry
/land	Jental Hyg Nental Hyg rised other tic event,	To Be C	17. Fether's Name (First, Middle, Last Gaylord Strawer	)				18. Mother's Neme	(First, Middle, M A. Hersh		ne)	
Many	affi and A 27 is ma or trauma		19e. Informent's Name/Reletionship ( GAIL HIGGENS Gail Higgins/da	Type, Print) ughter				et and Number or Rure on Avenue,				
) Baltimore, Maryland	Department of Hear mportant: If Item way Injury or other attics.		20e. Method of Disposition  1 ☐ Buriel 2 ☐ Cremetion 3 ☐  4 ☐ Openation 5 ☐ Other (Specia		comoto	f Disposition (Name ry, cremetory or oth		lece)	Dete	20c. Location	- City or To	wn, Stete
Del .	Physician /Medical Examiner		23s. Pert1. Enter the disease, or commonly index, or heert failure. List only immediate Cause (Final disease or condition resulting in death)	plicetions that ceuse one ceuse on each li	ardin	Baltimonot enter the mode	of dy	ress of Fecility atomy Boar e, Marylan ying, such es cardiac o	d 21201			Approximete Intervel Between Onset end Deeth
Division of Vital Records, P.O. Box 68760,	certificate be executed riding physician and use as the bunal-trensit		Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest	b	Due to (or es e	consequence of):						
, P.O. Bo	Attending Physician: The law requires that the death certificate by death.  ector: Affer this certificate hes been signed by the attending physic by the funeral director, page 2 should be detached for use es the b	by Physician/Medica	Pert II. Other significant conditions of	,	4	n the underlying car	use g	given in Pert I.	23b. Did to	1.	ontribute to	the cause of death?
ecords	e law requires the best been signed to 2 should be	Completed b							24e. Wes en	n eutopsy ned?	cor	ore eutopsy findings alleble prior to appletion of cause death?
Œ.	ysician: The lass certificate he director, page	E O							1 □ Ye	s 2 No	10	Yes 2□ No
/ita	certificate rector, pag	Be (	25. Was case referred to medical exeminer?					26. Plece of Deetl	h (Check only on	e)		
7	hysic this ce	0	1 ☐ Yes 2 No	Hospitel: 1 Inpatie		utpatient 3 DOA	'		me 5 Reside			1)
sion o	ttending Phy death. stor: After thi / the funeral	Certification:	27. Menner of Deeth  1 Neturel 5 □ Pending 2 □ Accident Investigation 3 □ Sulcide 6 □ Could not b		y Year)	М	1[	ork? □Yes 2□No	28d. Describe ho			
Divi	7575		4 Homicide determined	building, et		rm, street, fectory,			City or Town	, State)		l Route Number,
	To the Hospital of within 24 hours a To the Funeral D completely filled I	edical	29a. Certifier (Check only one) Certifying Ph	nysician: To the best niner: On the basis o end manner st	f examination en	d/or Investigation, I	the t	time, date end place, oplnion, death occurr	end due to the ce ed et the time, de	euse(s) end m ete end plece,	enner as st end due to	eted. the ceuse(s)
	To To Com	M	29b. Signature end title of certifier			29c.		nse number	2	9d. Dete signe	ed (Month, I	Dey, Year)

Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end manner stated. 29a. Certifier (Check only one) 29c. License number
29d. Dete signed (Month, Dey, Year)
September 14,1998 29b. Signature end title of certifier

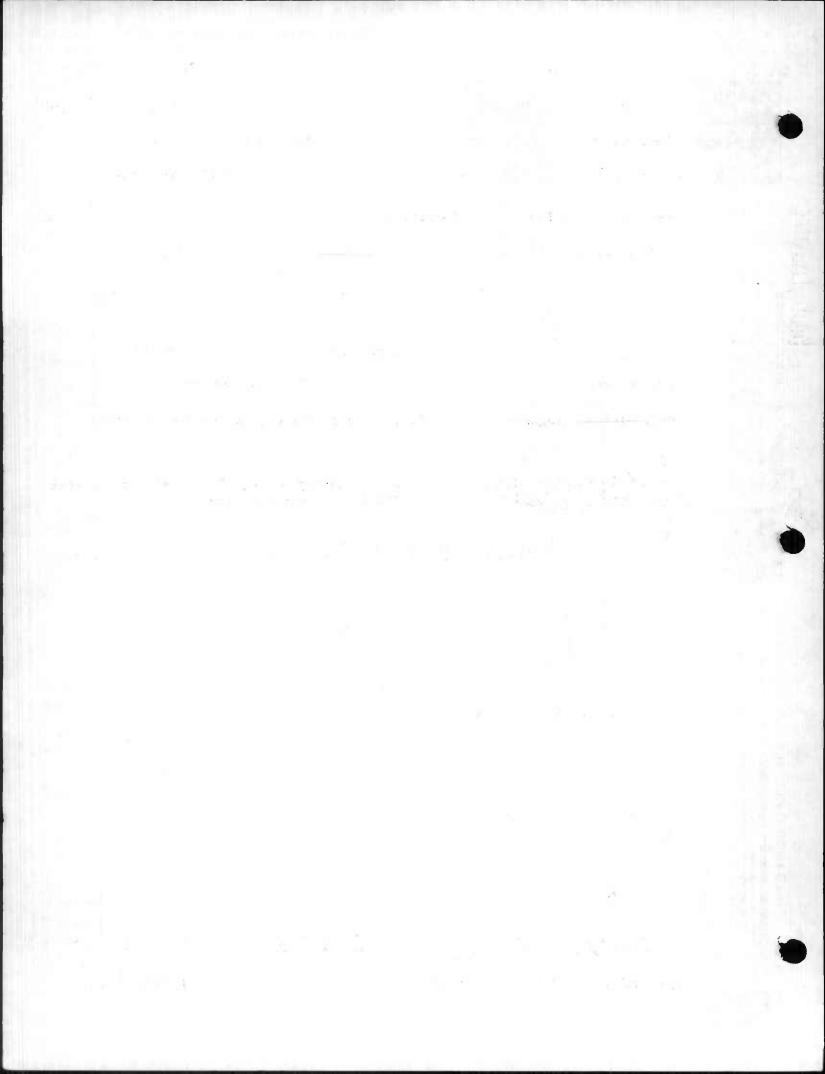
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

370 Mill Street

Hagerstown Maryland

State Registrar 31. Dete filed (Month, Day, Year)
SEP 1 8 1998

32. Registrer's Signeture



#### Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 20 AME Scotember 16. 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Liberty Modical Center. BALTHURE BALT: more, 21215 N/A Hours Min. 8. Date of Birth (Month, Dey, Year) If Under 1 Year | Months Days 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) MD 5. Sociel Security Number 15M 20 F 44 1953 212-60-9082 Usual Residence of Decedent 10d Inside City Limits 10a State 10b. County 10c. City, Town or Location XXves 2 No BALTO N/A MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21217 U.S.A. 1605 W. LANVALE ST 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Raca - American Indian, Biack, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married Specify BLACK 1 Yes 2 No Specify: Yeer or Dates: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A HOUSEKEEPER NUPSING HOME 10th 17 Fether's Name (First Middle I ast) 18. Mother's Name (First, Middle, Maiden Surname) THELMA SMITH JAMES KING SR 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) 21030 TRACEY KING 1003 I MISTYLYNN CIR 20b. Placa of Disposition (Name of cemetery, cremetory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation S ☐ Other (Specify) 9-21-98 BALTO, MD VOSHELL MEM GAR 22. Name and Address of Fecility BETTS FUNERAL HOME 21. Signature of Fundial Service Licenses 1129 N. CAROLINE ST BALTO, MD 21213 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heen feilure. List only one ceuse on each line. Approximate Intervei Between Onset and Death Adult Insuane Deficiency Dispose Immediate Cause (Final disease or condition resulting in death) DNEUmonia, Bilatera that initieted events resulting in death) Last nknown 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Yes No 1 Yes 2 No 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Examiner Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury

**Physician** 

/Medical

Director

Funeral

by

Completed

Be

Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

"natural",

should be filed within 7 and Mental Hygiene.

Pages 1 and 2 should be facilities of Health and Mental 9 int: If item 27 is marked of

permit. Pages Department of Important: If it any Injury or o

**Physician** 

/Medical

the Maryland

death v

72 hours after

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

The law requires that the death certificate

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certificate

funeral director,

filled in by

Hospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this certific.

Within 2 the

0

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Completed

Be

Certification: To

edical

Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

1 Yes 2 No 27. Manner of Death

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred

1 Naturai 5 Pending 2 Accident investigation 6 ☐ Could not be 3 Suicide 4 Homicide

28e. Placa of Injury - At home, ferm, streef, factory, offica building, etc. (Specify)

1 Yes 2 No

3Q. Name and eddress of berson who completed cause of deeth (Item 23g) (Type, Print

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier Kem wir 29c. License number 03 29d. Date signed (Month, Day, Year)

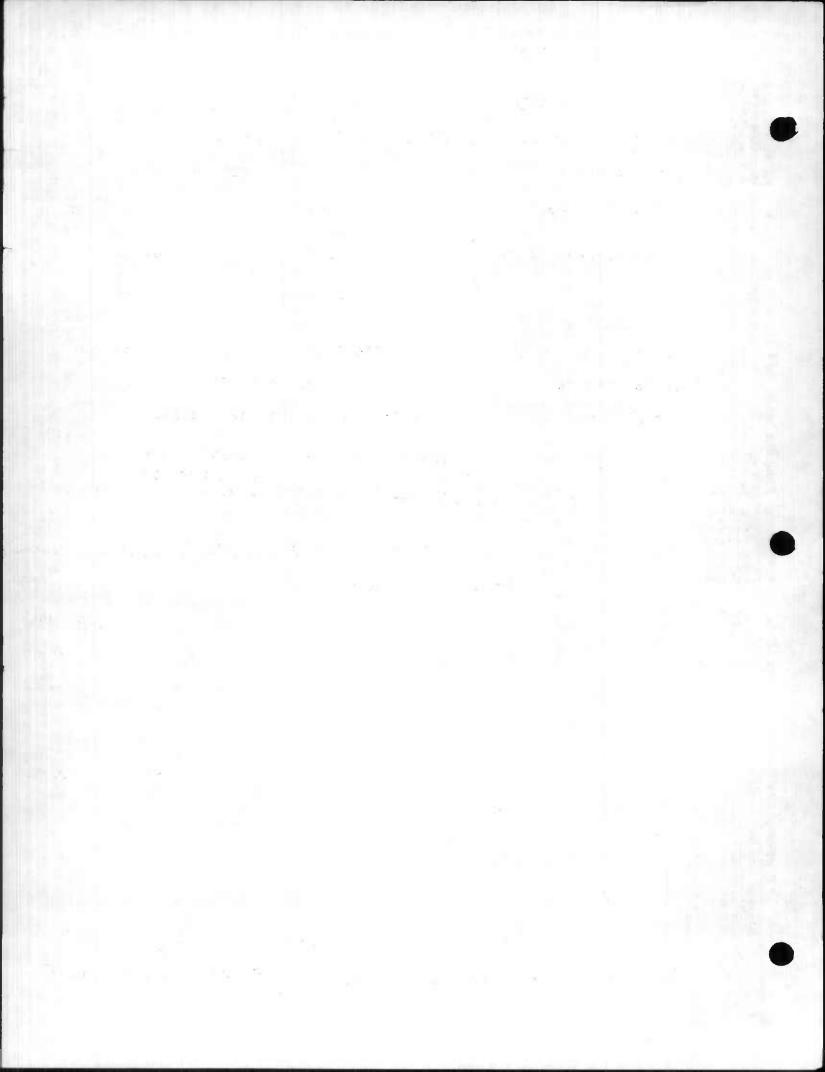
BALTIMORP. 21213

Registrar

31. Date filed (Month, Day, Year) 1 8 1998

Sira. MD 32. Registrar's Signature

2600 Liberty



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth September 14, 1998 Genevieve. A. Kelley 4:00 a.m. 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5613 North Lane Baltimore County Baltimore 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fo Country) 8. Bloamington, Ml. 5. Social Security Number 7. Age (In vrs. last birthday) if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex Days 1□ M 2QF Months Hours 219-28-7203 Usuai Residence of Decedent 10d. inside City Limits 10b. County 10c. City. Town or Location 1 ☐ Yes 2 ☑ No Maryland Baltimore Baltimore County 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5613 North Lane 21206 USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, 11 Merital Status Black. White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Housekeeping-Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sherman Warmick Frid Pauch 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred T. Kelley (Husband) 5613 North Lane Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 X Burial 2 Cremation 3 Removal from State Cardens of Faith Cem. Sept. 17, 1998 Baltimore, Maryland 4 Donetion 5 Other (Specify) 22. Name and Address of Fecility Lassahn Funeral Home, Inc. ature of Funeral Service Licensee le, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest. List only one cause on each line. 7401 Belair Road Baltimore, Maryland 21236-4625 Metastatic bread cance Immediate Cause (Final byears disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Dua to (or es e consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 PNo 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings svailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 20 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

ò

**Physician** 

/Medical

Examiner

10a. State

Directo

Funeral

by

Completed

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haaith and Mental Hygiene. Important: if Item 27 is marked other than "natures", or Items 23e or 28e-f show

Baltimore, Maryland 21215-0020

7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

attending physicia for usa as the bur the ed by the signed to been si should Completed

Physician/Medical Examiner

p

Be

Certification: To

Medical

29a. Certifier

hang

31. Date filed (Month, Day, Year) SEP 181998

The law requires that the death certificate be s cartificate has b Hospital or Attending Physicien: funeral director. this After death. Director: / in 24 hour.
the Funerel Directory

Division of Vital Records, P.O. Box 68760.

within 24 ho To the Fune completely f

To the

State Registrar 25. Was case referred to medical examiner? 1□ Yes 2□No 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturei 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

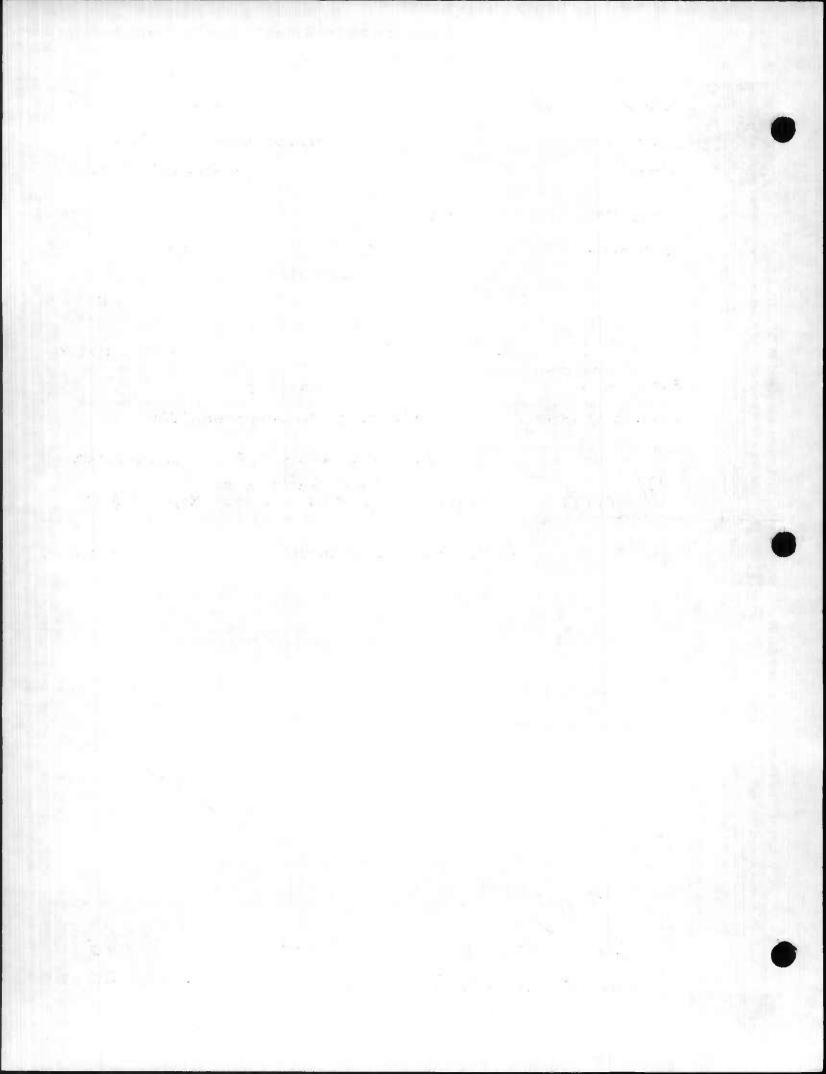
1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifie

D16587

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Blod, Doltmire, MD 21239 Kavan 560

\$2. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

28644 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Death Month **Physician** 19:20 pm WILLIAM LARKIN SEPTEMBER /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** UNIVERSITY OF MARYLAND MEDICAL SYSTEM

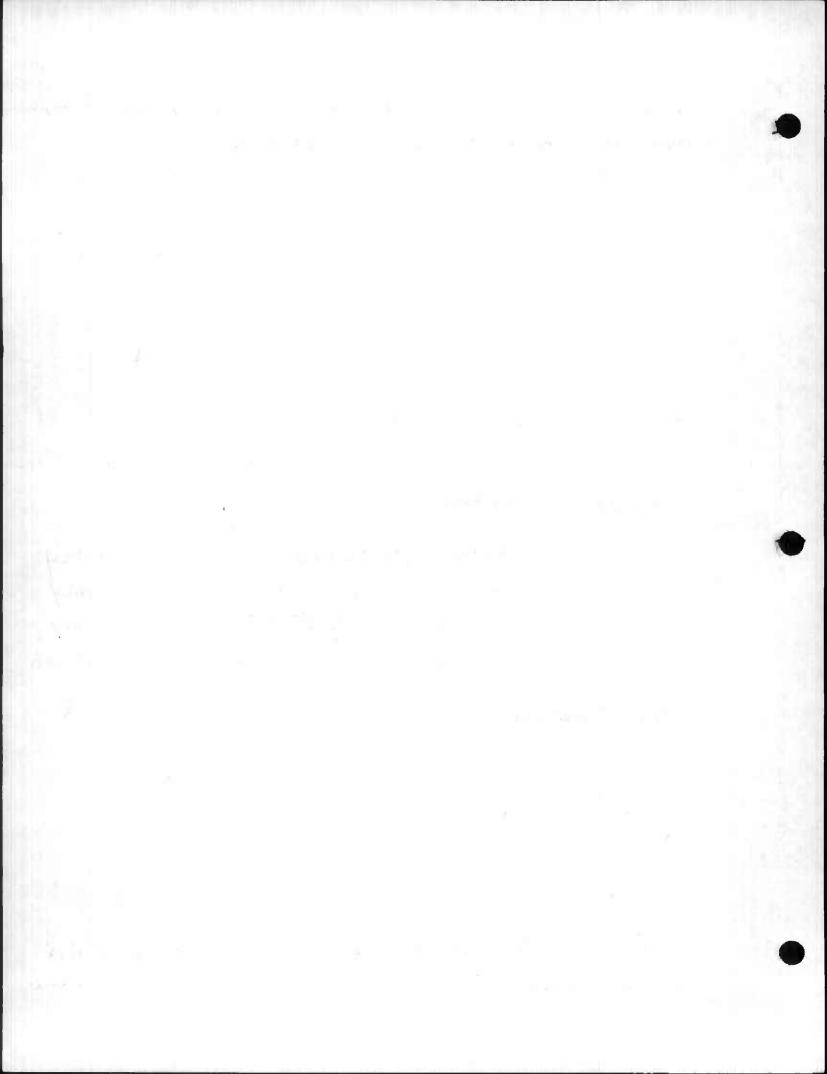
5. Social Sacurity Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Year

Months Deys BALTIMORE If Under 24 Hrs. 5. Social Sacurity Number 8. Data of Birth (Month, Day, Yaar) Birthplece (State or Foreign Country) **Funeral** NOMM 2□ F Deys 219-40-2690 57 Yrs Director July 26,1941 Maryland Usuel Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Locetion 10d. Inside City Limits 28a-f show ms 23a or 28a-f shov Maryland Baltimore Baltimore 1 ☐ Yes 27 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 303 Maiden Choice Lane 21228 United States Funeral Herne 12. Wes Dacadent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. other traumatic event, the Medical Examiner filed within 72 hours efter 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Year or Detes: 21215-0020 ò by 1 ☐ Yas 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white "natural". Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Dacadant's Education (Spacify only highest grade completed) 16b. Kind of Business/Industry / Hygiene. Elementary/Secondery (0-12) Collaga (1-4or 5+) Supervisor Computer other Maryland 17. Fether's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be finent of Heelth end Mental It intern 27 is merked of Roland D. Larkin Ann B. Imhoof 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Department of Heelth er Important: If item 27 is any injury or other trau once. Ann B. Larkin, Mother 303 Maiden Choice Lane Baltimore, MD 21228 Baltimore, 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cramation 3 ☐ Removel from State 4 □ Donetion 5 □ Other (Specify) 9/19/98 Woodlawn, Maryland Woodlawn Cemetery 21. Signature of Funeral Service Licenses 22. Neme and Address of Fecility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road Maryland 21227 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or heart feilure. List only one cause on each lina. Approximate Interval Between Onset end Deeth **Physician** Immediate Ceusa (Final diseese or condition resulting in death) /Medical Examiner Examiner ARDIORESPIRATORY The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated avents rasulting In death) Lest Box 68760. Physician/Medical Due to (or as e consaquance of) RACHESENOMINANT esn Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No IRANSPLANT Division of Vital Records, ð 24b. Wera autopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed this certificate has 1 Yes 2 No 1 □ Yes 2 □ No Attending Physician: 25. Wes case raferred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) To 1 Yes 2 No del or Atte.
Juss effer deeth.

\*\*al Director: After th funeral 27. Menner of Deeth Certification: 28d. Describe how Injury occurred 1 XNatural 5 Panding investigation 1 Yes 2 No 2 Accident 6 Could not be 28e. Placa of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida To the flospital o within 24 hours et To the Funeral Di completely filled in Medical 29a. Cartifier 12 Certifying Phyeician: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) and mannar as stated.
2 Madicat Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, date end place, end due to the causa(s) and manner stated. (Check only one) 29b. Signeture end title of certifian 29c. License number 29d. Dete signed (Month, Day, Year) O. Colone of mo SEPTEMBER 16 1998 30. Name and address of parson who completed causa of daath (Item 23e) (Type, Print) 225, GREEN STREET BALTIMORE, MARYLAND COLONN II 31. Date filed (Month, Day, Year) SEP 181998 82. Registrar's Signeture

DHMH 16 Rev 6/95

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Deeth 3. Time of Death **Physician** GEORGIA VIRGINIA LISSAU 15, 1998 11:50 a.m 4c. County of Death SEPT. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Catonsville Baltimore 1210 FREDERICK ROAD If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Day, Yaar) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1□ M 210 F Yrs. Director 216-05-7248 81 2/4/1917 West Virginia Usuel Residence of Decedant filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yas 2 X No Director MD Catonsville Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? than "naturel", or items 23s or the Medical Examiner must be United States 1210 FREDERICK ROAD 21228 Funeral 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Rece - American Indian Black, White, etc. 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Dates: 1 □ Navar Merried 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🛣 No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Dacedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast greda complated) 16h. Kind of Business/Industry Collaga (1-4or 5+) Elamantary/Secondary (0-12) 12 Homemaker Own Home 7 is marked other traumatic event, 18. Mothar's Nama (First, Middla, Maiden Sumema) 17. Fathar's Nema (First, Middla, Last) Be Peges 1 and 2 should be 1 nent of Health and Mental F int: If item 27 is marked ot Rev. Charles Stanley Mary Smith 19b. Mailing Address (Streat end Number or Rural Routa Number, City or Town, Steta, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 1210 Frederick Rd. Catonsville, Md. 21228 Carolyn M. Lissau/Daughter other t 20b. Place of Disposition (Nama of cematary, cremetory or other pleca) Deta 20c. Location - City or Town, Stete 20a. Mathod of Disposition 1 X Burlel 2 Crametion 3 Removel from State 5 = rtant: If 4 ☐ Donation 5 ☐ Othar (Specify) Meadowridge Memorial9/19/98 Dorsey, Maryland 21. Signature of Funaral Servica License 22. Nama and Addrass of Facility Ambrose Funeral Home, Inc. 23. P. fri. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, mock, or heart feilure. List only one ceuse on each line. Arbutus, Maryland Approximata Interval Between Onsat and Death Physician tmmediata Causa (Final disaasa or condition resulting In death) /Medical PULMONARY HYPERTENSION 3-5 yrs Examiner Due to (or as a consequanca of): Examine EMPHYSEMA AND CHRONIC BRONCHITIS 8-10 yrs physician and s the burial-trans Sequantially list conditions, if any, laading to immadiate cause. Entar Undarfying Causa (Disease or injury that Initieted avents rasulting in death) Lest Due to (or es a consequance of): Box 68760 CIGARETTE CONSUMPTION YRS certificate be Physician/Medical Due to (or es a consequance of) 80 esn signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. TY Yee 2 No 3 Probably 4 Unknown OSTEOPOROSIS WITH COMPRESSION FXS. Records, þ 24b. Wara autopsy findings eveilable prior to 24e. Wes an autopsy performed? Completed HTPERCHOLESTEROLEMIA complation of causa of death? page 2 s hes DEPRESSION 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was casa rafarrad to medical axaminar? Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Yaar) 28d. Dascribe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Panding efter deeth. 1 ☐ Yas 2 ☐ No investigation 2 Accidant 6 ☐ Could not be datarmined 3 Sulcida 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 28a. Placa of Injury - At home, farm, straat, factory, office building, atc. (Specify) 4 Homicida 6 Illed in 24 hours of Funeral 1 Certifying Physician: To tha best of my knowledge, daath occurred at tha tima, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end mannar stated. 29e. Cartifiar Medical (Check only one) To the 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Yaar) 0-22875 Smulli Juno Jus 30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print) 3449 Wilkens Dennis Smith, M.D. Avenue Baltimore, Maryland 21229 32. Aegistrar's Signatura 31. Dete filed (Month, Dey, Year)

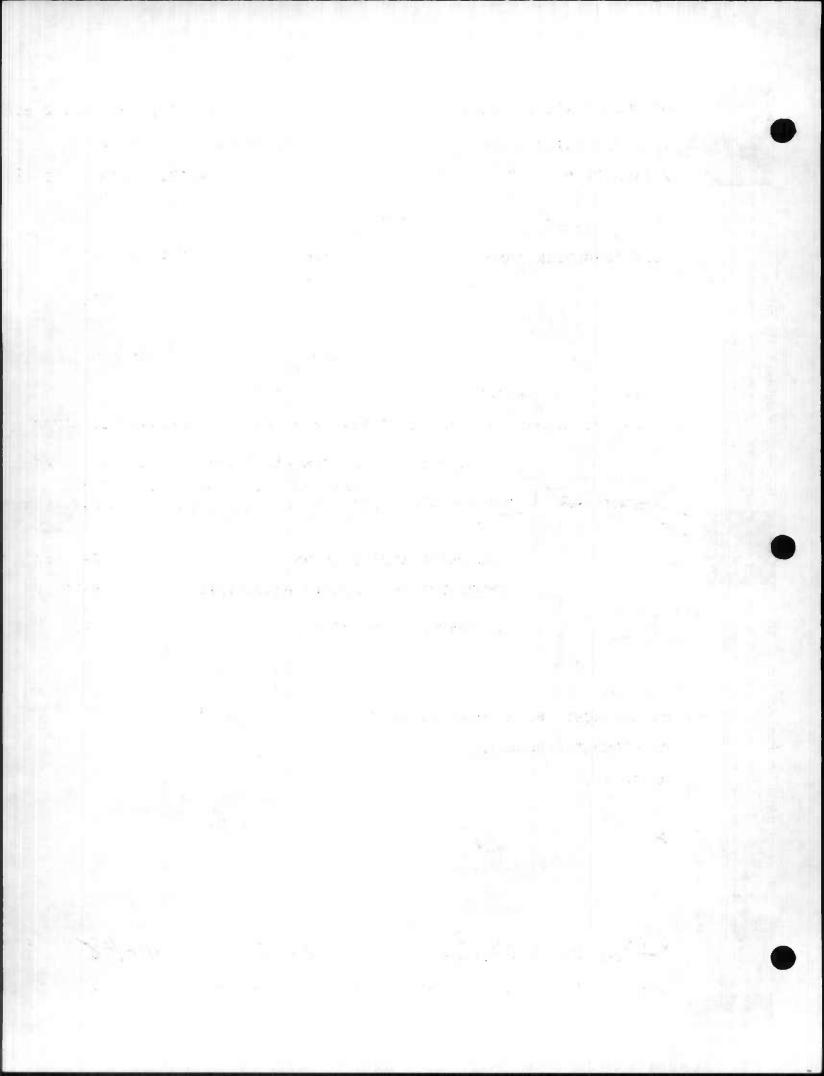
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DHMH 16 Rev 6/95

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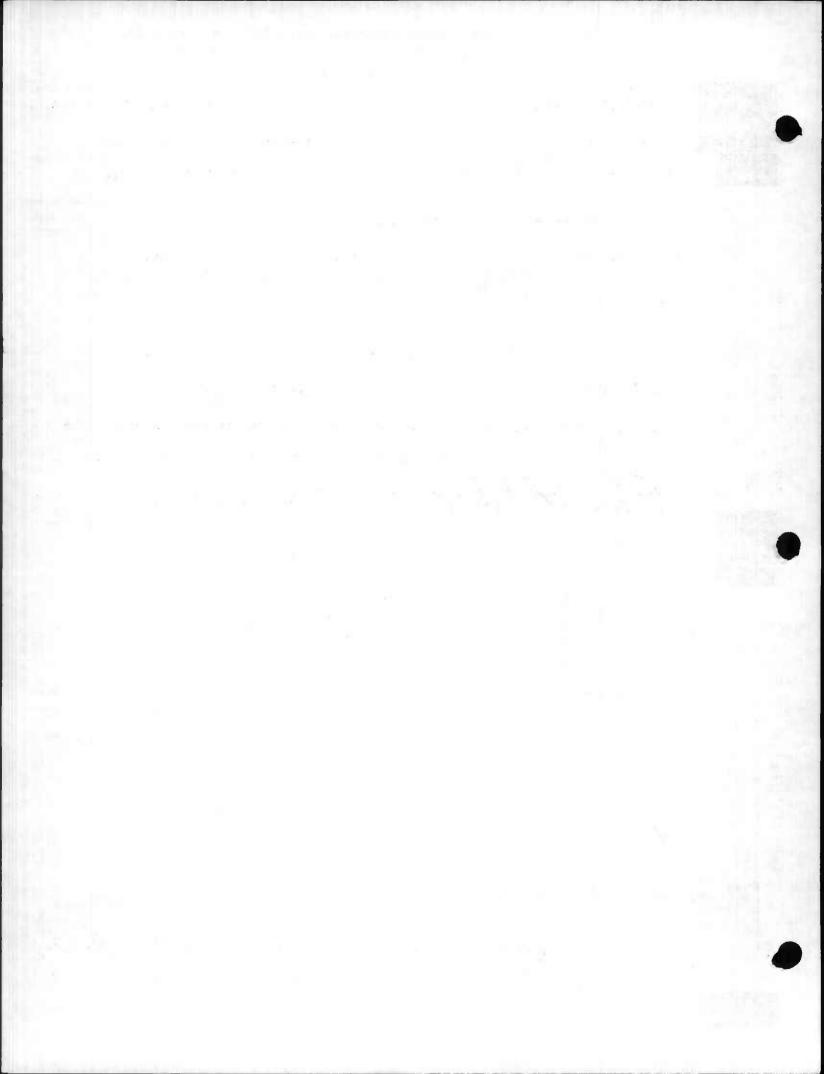
Registrar

SEP 1 8 1998



State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day 16, Jerome Michael Lichtenberg, Jr. SEP 1998 10:40 PM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death 6712 Montgomery Road Elkridge Howard 7. Aga (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Sacurity Number Days 1⊠M 2□ F Yrs 219-34-0547 61 July 7, 1937 Maryland Usual Residenca of Decedent 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 2 ☑ No Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6712 Montgomery Road 21075 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Naver Married 2 Married White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Yard Jockey Trucking 12 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Sumame) Jerome M. Lichtenberg, Sr. Evelyn Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Patricia Lichtenberg/Wife 6712 Montgomery Road Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burlal 2 Cremation 3 ☐ Removel from Stata 09/17/98 Metro Crematory, Inc. Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licenses 22. Nama and Address of Facility Edward A. Cremation Society of MD, Inc. Edward A. Green Lations that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heer feilure. La trily one cause on each line. 299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death Immediate Cause (Final LARYMAN Cancer 15 months disease or condition resulting in death) Due to (or as e consequence of): Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequenca of): 23b. Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 15 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Death 1 Netural 28b. Time of 28d. Describe how Injury occurred

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 end 2 should be filed within 72 hours effer of Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other treumatic event, in Mentel Example and English Pages.

Director

Funeral

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Completed

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ettending physiclen end for use es the bunel-transit signed by the e hes he 2 certificate her

Physician/Medical Examiner that the death certificate be executed Completed by Be P this Certification:

P.O. Box 68760.

Division of Vital Records. or Attending Physician: death. Director: /

> State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of cartifier

12/10/148

PICHULUS HOLLTRELAKUS

2 Accident

3 Suicide

29a, Certifier

4 - Homicide

(Check only one)



Joules 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending invastigation

6 Could not be determined



wis

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner es steted. 2 Medical Exeminer: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated.

> 29c. License number 29d. Date signed (Month, Day, Year)

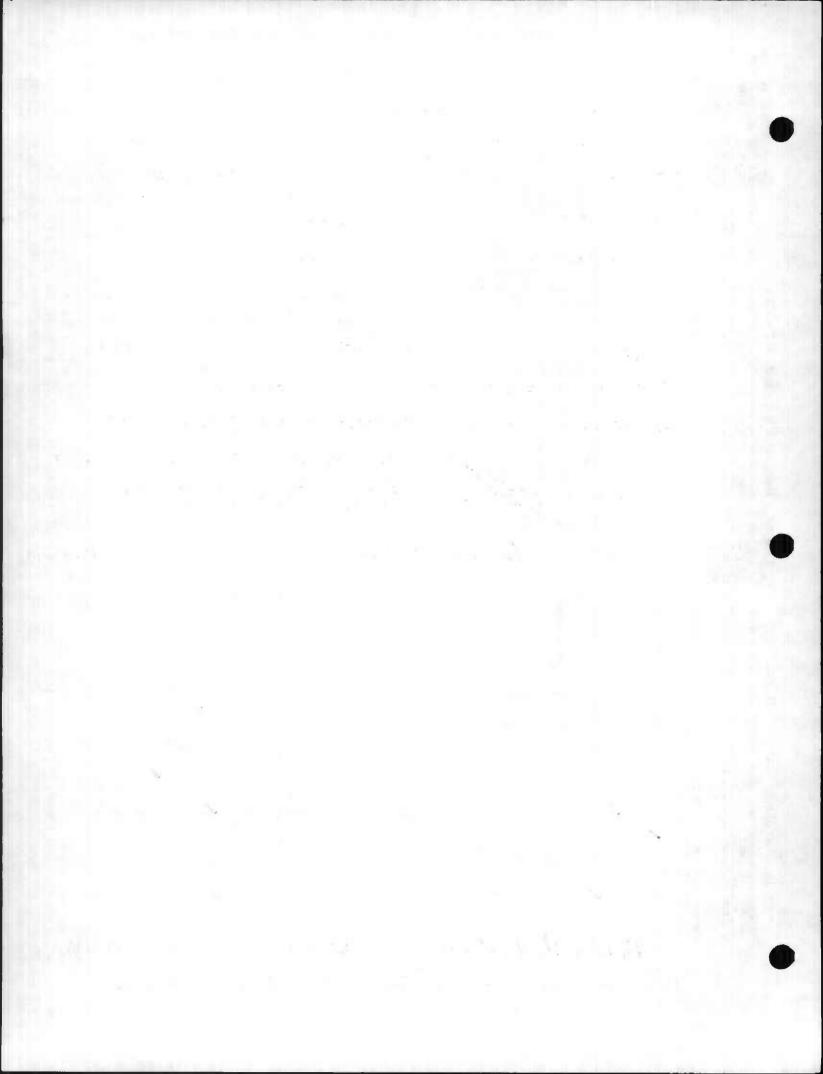
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

September 17 1998

11065 Little Paruxent Phony Columbia MD 21044

1 ☐ Yes 2 ☐ No

038509



State of Man

yland /	Department of	of Health and M	lental Hygiene
		4	

Certificate of Death Reg. No 1. Decedant's Nama (First, Middle, Last) 2. Data of Deeth **Physician** SEPTEMBER 14 1998 WILLIAM EDWARD LYCETT /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner ANNE ARUNDEL COUNTY HART HOME HOSPICE (8016 Ritchie Hwy.) SEVERNA PARK 8. Date of Birth (Month, Dey, Year)
July 30 1910 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. **Funeral** Deys 1**X** M 2□ F Months Hours Min 213-09-6640 88 Director Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland neat of Health and Mental Hyglene.

The should have a should the should have 25 and 25 10e Stete 10c. City, Town or Location 10b County Md. Baltimore Director n/a 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21230

404 Sanders Street

Funeral

by

Completed

altimore, Maryland 21215-0020

Division of Vital Records, P.O.

Department of Important: If any Injury or

**Physician** /Medical

Examiner

Physician/M

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Completed

BB

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Certification:

edical

page 2

certificate

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or Attending

11. Meritel Status 1 ☐ Never Merried 2 ☐ Merried 3 Widowed 4 □ Divorcad

12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yes, Give A Yaar or Datas; 15. Decadant's Education (Specify only highast grede completed)

College (1-4or 5+)

1 ☐ Yes 2 ☐ No Specify:

16a. Decedent's Usuel Occupetion (Giva kind of work dona during most of working life. DO NOT use retired) Truck Driver

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.)

Exxon 18. Mother's Neme (First, Middle, Maiden Surname)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

Elizabeth Thomas

17. Fether's Neme (First, Middle, Last) Walter Lycett

Elementery/Secondery (0-12)

19a. Informent's Name/Reletionship (Type, Print) Janice C. Rutkowski (daughter) 557 Crestpark Drive, Glen Burnie, Md. 21061

1X Buriel 2 ☐ Crametion 3 ☐ Ramoval from Stete

20b. Plece of Disposition (Neme of cemetery, crematory or other plece)

. 17 20c. Location - City or Town, State Sept. Glen Haven Memorial Park Glen Burnie, Md.

4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licensee

23e. Perty Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilura. List only ona ceuse on each line.

McCully-Polyniak Funeral Home 130 E. Fort Ave. Baltimore, Md. 21230

Immediete Ceuse (Final disaesa or condition resulting In death)

20e. Method of Disposition

enosco

riosc Due to (or as a consequence of)

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in deeth) Lest

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contributa to the cause of death?

1 Yes 2 No

3 Probably 4 Unknown

28648

3. Time of Death

5:55 AM

9. Birthplece (Stete or Foreign

10d. Inside City Limits 1 XYas 2 □ No

Maryland

USA

14. Race - American Indien, Black, Whita, atc.

Specify: white

16b. Kind of Business/Industry

24e. Wes en eutopsy

ardiovascular Oberse

24b. Were autopsy findings available prior to completion of cause of deeth?

Approximata Interval Between Onset end Deeth

1 Yes 2 No 26. Place of Deeth (Check only one) Hart Home Hospice

1 ☐ Yas 28 No

25. Wes case referred to medical examiner? 1 Yas 2 No

1 | Inpatient 2 | ER/Outpetient 3 | DOA 5 Pending

investigation

6 Could not be determined

28e. Date of Injury (Month, Dey Year)

28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

27. Magner of Deeth

Neturel

2 Accident

4 Homicide

3 Suicide

1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date end placa, end due to the ceuse(s) end manner es steted.

2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) and menner steted.

29b. Signature and titla of cartifian

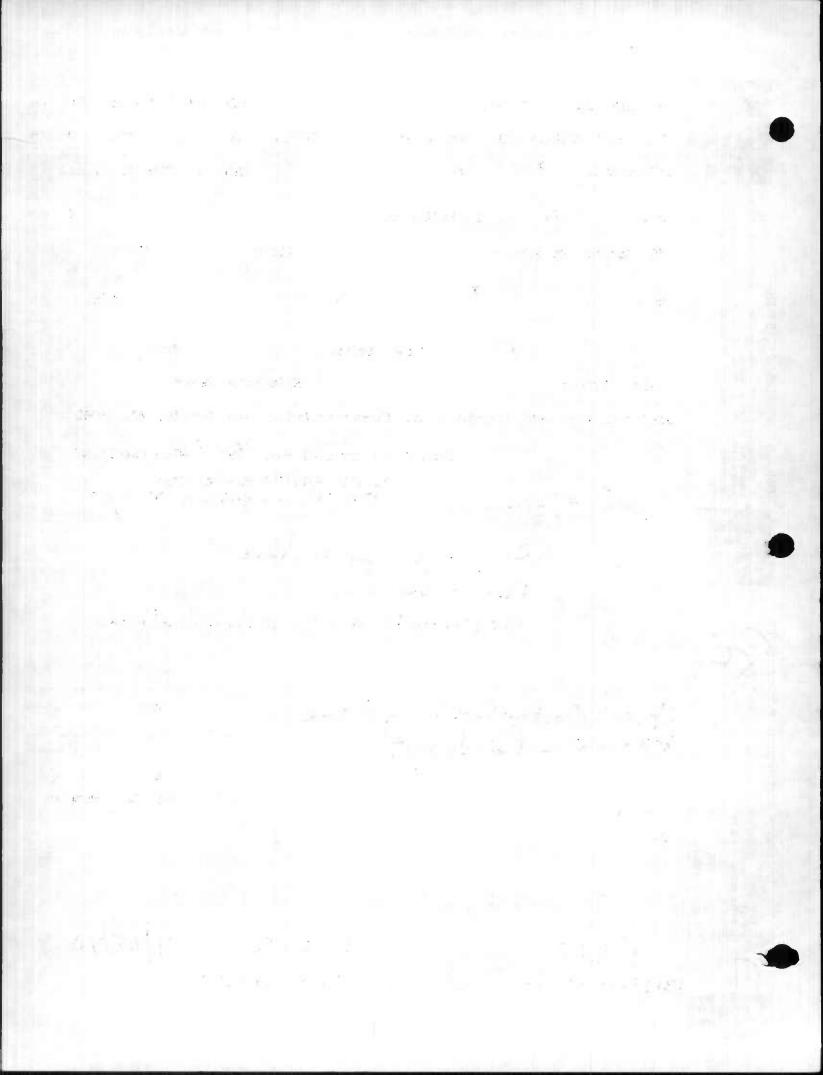
29c. Licensa number

29d. Dete signed (Month, Dey, Year)

of person who completed cause of deeth (Item 23e) (Type, Print) more

State Registrar 31. Dete filed (Month, Day, Year) SEP 1 8 1998

32. Registrer's



-North

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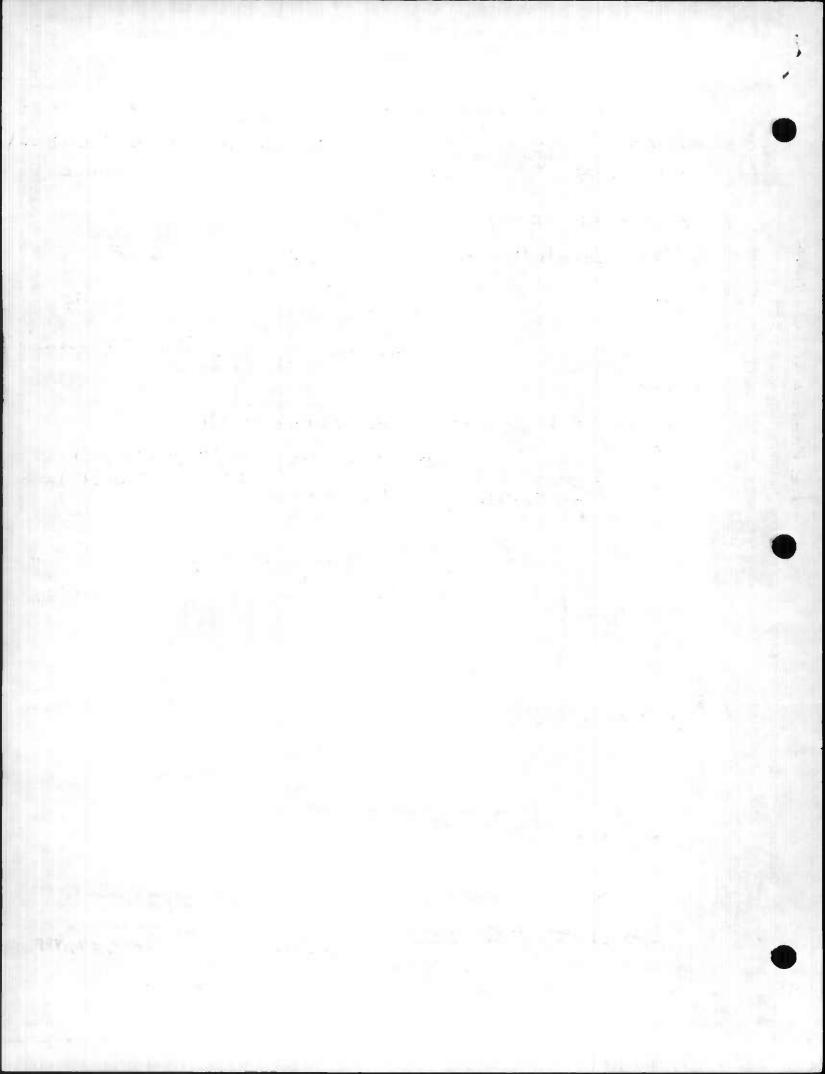
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State

Registrar

31. Date filed (Month, Day, Year)

181998



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Month Day **Physician** ELSIE Lawson SEPTEMBER 1998 10:36AM 16 /Medical 4a Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Undar 1 Yaar | Months | Days Birthplaca (Stata or Foreign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Undar 24 Hrs. 1□ M 200 F 8. Data of Birth (Month, Day, Year) **Funeral** Hours 242-16-9211 MARYLand Director 4-21-1 Usual Rasidance of Dacedant 10a. Slata 10b County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or itema 23a or 28a-f show trsumstic event, tra Modical Examiner must be notified as Baltimore 1 Yas 2 □ No MARYLAND Funeral Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Loch Raven 21239 USA 5204 12. Was Decedani Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Biack, Whita, atc 1 Navar Marriad 2 Married 1 Yas 2 No Specify: by BLack 3 ₩Widowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) Completed 15. Decedant's Education (Spacify only highest grade completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Domestic Homemaker 18. Mothar's Nama (First, Middla, Maidan Sunnama) 17. Fathar's Nama (First, Middla, Last) Be UKn UKn 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) WENdy Loch Raven Brud. Lomax 5204 20b. Place of Disposition (Nama of cematary, cramatory or other place) mportant: If item iny injury or othe 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Separtment of 1 Burlal 2 □ Cramation 3 □ Ramoval from Stala Balto, Md. 23/98 Voshell Cometer 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Fineral Service Coens 22. Nama and Addrass of Facility 1639 N. BROadway Basto. Mol 23a. Part 1. Egilar the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final 10 mins disaasa or condition rasulting in daath) Examiner Physician/Medical Examiner conaci physician end s the burial-trensit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Diseasa or Injury that Initiated avants rasulting in death) Last on gestive H Heart Peri 9 Vascular Disease ever phera been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 ☑ Onknown 1 Yes 2 No by 24b. Wara autopsy findings availabla prior to complation of causa of death? Completed 24a. Was an autopsy s certificete hes b 1□ Yas 21 No 1 ☐ Yas 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this cardine completely filled in by the funeral director; Be 25. Was casa rafarrad to medical 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant Certification: To 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred 5 Panding invastigation 1 Natural 1 🗆 Yas 2 No 2 Accidant 6 Could not be datarmined 3 Suicida Place of Injury - At homa, farm, streat, factory, office building, afc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licansa number

125349

29d. Data signed (Month, Day, Year)

6565 N. Charles Suite 605, Battimore

State Registrar

edicai

4 Homicida

29b. Signature and title of certain

31. Data filed (Month, Day, Yaar) SEP 18

J

30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

Golueke

32. Ragistrar's Signatura

29a. Certifian (Check only one)

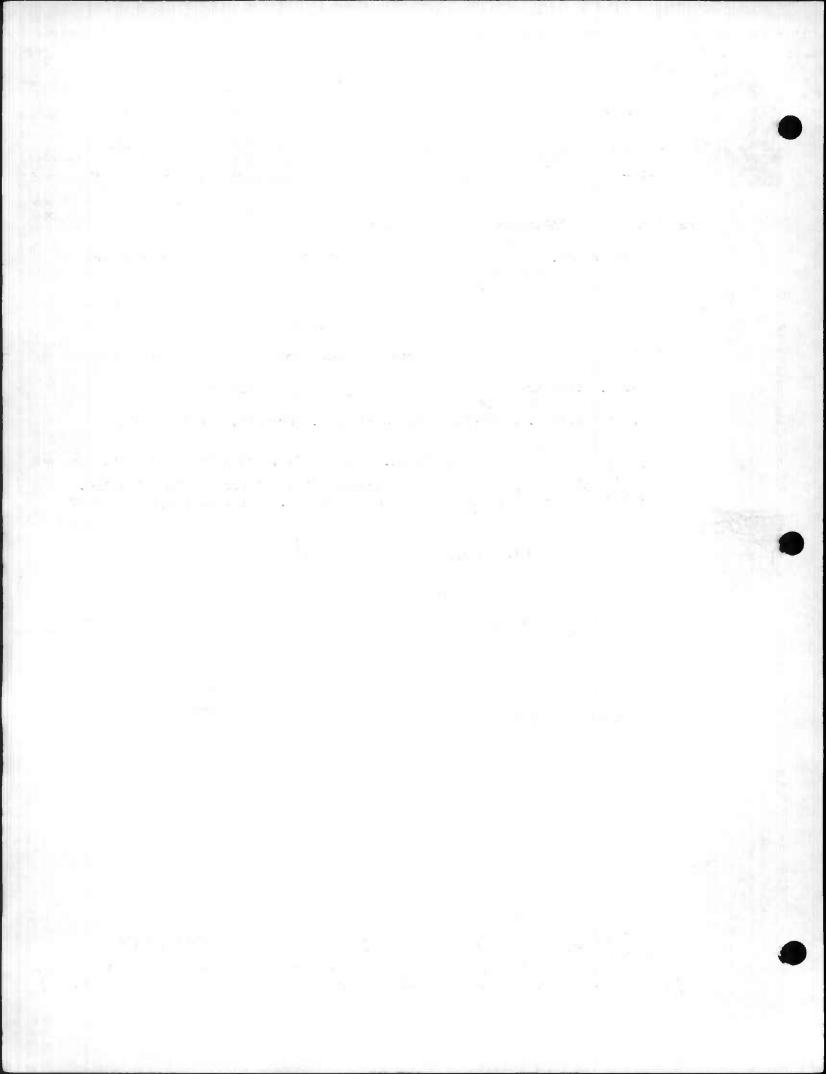
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awson,

Division of Vital Records, P.O. Box 68760,

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ner	4a. Facility Nama (If no	11	. 1		11.			Location of Deat	h 4c. Count	
	5. Social Security Numi			Aga (In yrs. I	MEDICAL	Undar 1 Yaar	If Undar 24 Hrs	MORE	th	N/A
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_	10a. Stata 10	0b. County		10c. City	, Town or Location	ion				10d. Insida City Limits
cto	Maryland		altimore		D1	undalk				1 □ Yas 2 No
Director	10e. Street and Numbe				1	10f. Zip Coda			10g. Citizan of	What Country?
erai	411 Ste	efan Ct		P I- 14 f	0 40 11		222			d States
by Funeral	11. Marital Status  1 Navar Married  3 Widowed 4		12. Was Daceda Armed Force 1  Yas 24 If Yas, Giva Yaar or Data	as? EXNo			Ispanic Origin? (3 in, Maxican, Puar Specify:	Specify Yas or No rto Rican, atc.)	Special	ce - Amarican Indian, ack, Whita, atc. fy: White
Completed		. Decedant's E			16a. Decedant	's Usual Occup	etion		16b. Kind of B	Businass/Industry
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Con	11 Year	cs			Fork 1	Lift Op	erator		Steel	Industry
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2	Oscar A			-			Ester	Sidden		
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	20a. Mathod of Disposit		e D. Dille	-						21222
	1 ₺ Burial 2 □ C	Cramation 3	☐Ramoval from Sta	ald .	aca of Dispositio			Data		- City or Town, Stata
	4 Donation 5			7 gac	-			9/17/19	98 Dur	ndalk, Maryland
	23a. Part1. Entar tha d shock, or haart fa	100	· for	4/	Di 79	922 Wis	k Funera e Ave.	Dundalk	Maryla	alk, Inc. and 21222
	Immediata Causa (Fina	al	101.				2			
dical Examiner	Immediata Causa (Find disaasa or condition rasulting in death)  Sequantially list condition and the condition of the causa (Disaasa or injurtat initiated avants rasulting in death) Last	tions, idiata ing		Dua to (or Dua to (or	as a consequan	nce of):  UMONI  Ice of):  LITUS				HOMINUTE
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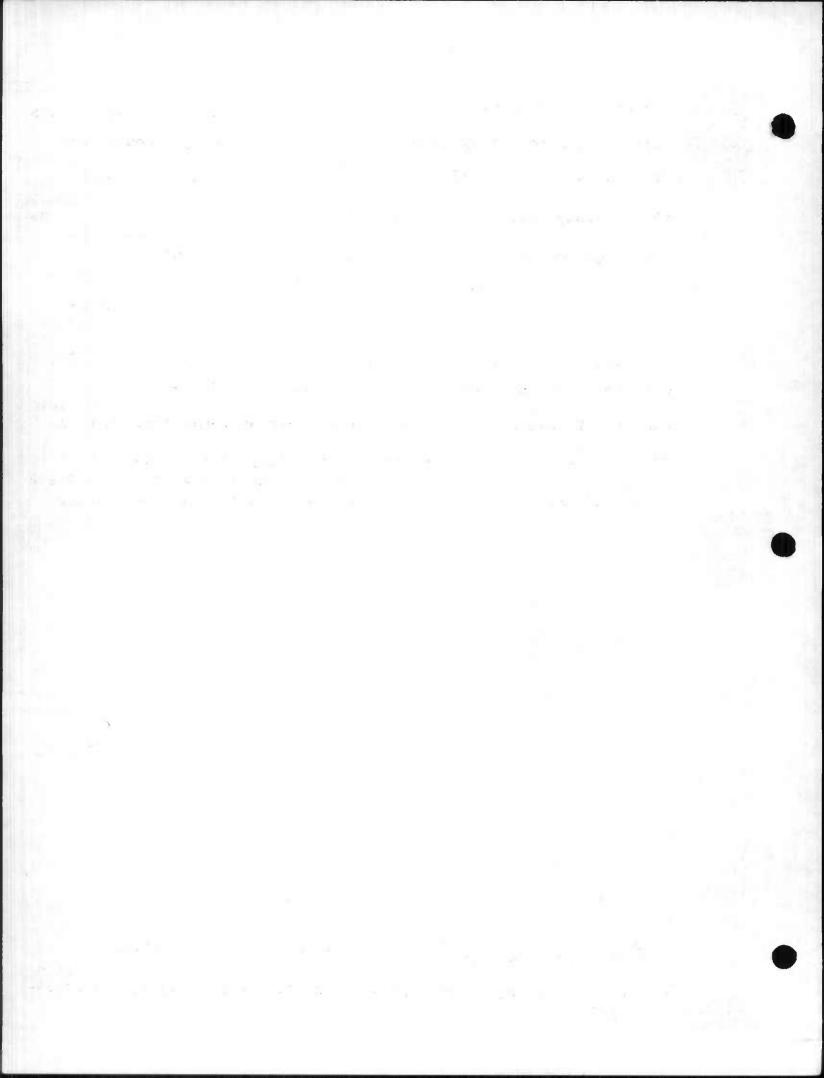


State of Maryland / Department of Health and Mental Hygiene 9

					C	ertificat	e of	Death			Reg. No.			
Physic /Med		1. Decedent's Name (First, Middle, La  CODY MERA	St) EDITH	+	10					2. Date of De Month	ath Day	Year 1998		ne of Death
Exam		4e. Facility Name (If not institution, give Saint AGNES		mber) Mhca	RE			4b. City, Town	n, or Loc	cation of Death	4c. Count	y of Death		
Funera Directo		5. Social Security Number 6. S  None  Usuai Residence of Decedent	Sex IDM M 2□ F	7. Age (In yrs	. lest birthda Yrs.	y) If Under Months			Hrs. Min. 13	8. Date of Bir Month, De Sept	th y, Year) 15 1998	9. Birthpi Coun	iace (Ste try)	ete or Foreig
ith the Maryland or 28a-f show	tor	10a. State 10b. County	imore		ity, Town or Balti						1	10		de City Limits
with the 3a or 28a	i Director	10e. Street and Number  3 University A			.,	10f. Zip	Code	8			10g. Citizen of		try?	A
be filed within 72 hours after death with the Manyland lat Hygiene.  did other than "natural", or items 23s or 28s-f show event, the Medical Evantral must be notified at	by Funerai	11. Maritai Status  1 2 Never Married 2 Married 3 Widowed 4 Divorced	_	2 ŽNo ive	J,S. 1:	3. Was Deced If Yes, spec	cify Cub	Hispenic Originan, Mexican, Specify:	n? (Spec Puerto R	cify Yes or No	- 14. Ra	ce - America ack, White, e	an India etc.	n,
d within 72 hours af giene. Ir than "natural", or the Medical Exam	leted	15. Decedent's Ed (Specify only highest gre	ducation ade completed)		16a. Dec	cedent's Usua ve kind of wo . DO NOT u	al Occu rk done	pation during most o	of workin	g	16b. Kind of B	Business/Ind	Justry	
202	Completed	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	NIA	1-4or 5+)	me	/	V/A		N. C.	(Fine 84: 44)		N/A		
d 2 should be file th and Mentai Hy 7 is marked oth traumatic event	To Be	Rich O. Meredi								Raucht	Maiden Sumer	ne)		
s 1 and 2 should be if Health and Mental itam 27 is merked o	-	19a. Informant's Name/Relationship (	Type, Print)		19b. Ma	iling Address	(Stree				er, City or Town	, Stete, Zip	Code)	
of Health a itam 27 is		Rich O. Meredi	th		3 [	Jnive	rsi	ty Ave	enue	Balt	imore	, MD	217	228
Physician and Medical Examiner is seen the burial-Irensit	Medical Examiner	shock, or heert failure. List only Immediate Cause (Finel disease or condition resulting in death)  Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	e. Fri	Due to (	or as a cons or as a cons he te	requence of):	TUR	e or	T M	lem	brano	, C	Intervel Onset e	imete I Between end Death
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thet the dended by the a	by Phys				John Williams	ditodiying o	adob gi	VO. 11 1 U. 1.		10				4 Unkno
a law requires thet has been signed b je 2 should be dete	Completed b										an autopsy imed?	ava	allable pr	psy findings rior to n of cause
The ate	_									10	Yes 20 No	1 [	Yes	2 No
Physician: The this certificate ral director, page	o Be	25. Was case referred to medical exeminer?  1 Yes 2 No	Hospital:	lanation OF	TD/Outrot	O D	Ot	her:		(Check only o		h 1016		
After fune	-	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date (Mon		28b. Time Injury	of 2	Bc. Inju	ry et	21		dence 6 □Oti how injury occu		7	
tal or Attending is after death. ai Director: After ed in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place	of injury - At hing, etc. (Speci	ome, farm,	street, factory			-	8f. Location (: City or Tox	Street end Num vn, Stete)	ber or Rure	Route	Number,
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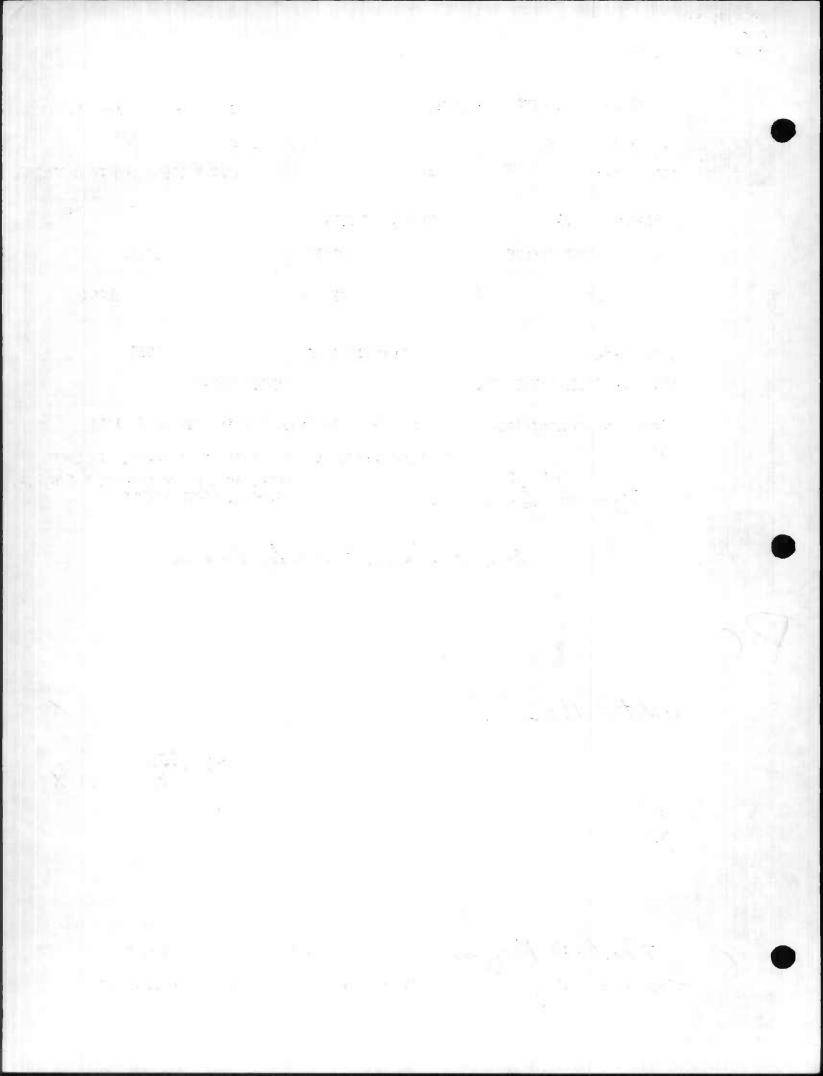
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State of Maryland / Department of Health and Mental Hygiene

CLARA E.	MEREDITH State of Maryland / Department of Health and Certificate of Death		ene 98 28654
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Physician /Medical	CLARA ELAINE MEREDITH	SEPTEMBE	R 12, 1998 1600PM
Examiner	4108 BRENDAN AVENUE BALTIMO	ORE CITY	4c. County of Death N/A
Funeral Director	5. Social Security Number 218-52-1279 6. Sex 1 M 2 XX 48 Yrs. 6. Sex 48 Yrs. 6. Sex 48 Yrs.	lin. (Month, Day,	9. Birthplace (State or Foreign Country) 1950 NORTH CAROL INA
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death with the Maryland rms 23a or 28a-1 show rmust be notified at neral Director	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1XX es 2 □ No
vith the Ma	MARYLAND N/A BALTIMORE CITY  10e. Street end Number 10f. Zip Code	10	g. Citizen of What Country?
h with	4108 BRENDAN AVENUE 21213		U.S.A.
Print		(Specify Yes or No- uerto Ricen, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
Ind 21215-0020 be filed within 72 hours et tal Hygiene. d other than "natural", or event, the Medical Exam Be Completed by F	15. Decedent's Education (Specify only highest grede completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of the complete of the c	working 1	6b. Kind of Business/Industry
within 7 within 7 within 7 with an "r than "r	(Specify only highest grede completed) (Give kind of work done during most of life. DO NOT use retired)  Elementary/Secondary (0-12) College (1-4or 5+)	WOIKING	2000
filed v Hygier the rule of Co	12th grade FOOD SERVICES 17. Father's Name (First, Middle, Last) 18. Mother's I	Neme (First, Middle, M.	BCSS aiden Sumame)
Maryland d 2 should be file th end Mental Hy 7 is marked oth traumatic event	CLYDE McKINLEY DAVIS, SR. LUCEN	DIA DAVIS	,
ary shou and M amer umet	19a. Informant's Name/Reletionship (Type, Print)  19b. Melling Address (Street and Number of	Rural Route Number,	City or Town, State, Zip Code)
end 2 ealth e	Brenda R, Hinton/Sister 805 Van Dyke Lane,		
Baltimore, semit. Pages 1 el separtment of Heamportant: if item my injury or otherance.	20a. Method of Disposition  XX Burial 2 □ Cremation 3 □ Removal from State  20b. Placa of Disposition (Name of cemetery, crematory or other place)		0c. Location - City or Town, State
E La	4 □Donetion 5 □Other (Specify) WOODLAWN CEMETERY  21. Signeture of Funeral Service Logisco  22. Neme end Address of Facility 1.		OODLAWN, MARYLAND
Balt permit. Depart imports any inj	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	06 W. NORTH	
Examiner and as the chiral examiner fedical Examiner	Cause (Disease or Injury that Initiated events resulting in deeth) Last  Due to (or as a consequence of):	Oses	
of by the attending pleated for use as	d		
yal sed y	Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to the cause of death?
s that e ned by e detac	Dobets Millity	_   10 10	s 2 No 3 Probably 4 Unknown
The law requires that hat been signed to page 2 should be det.		24a. Was en perform	ed?  available prior to completion of cause of death?
VITAL Ician: Th certificate rector, pa		Death (Check only one	
1 4 4 5 P	1 ⊈Yes 2 □ No Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursin		nce 6 Other (Specify)
Attending at death. sector: After by the tuns	27. Manner of Death   Natural   5   Pending investigation   2   Accident   3   Suicide   4   Homicide   6   Could not be determined   4   Homicide   28e. Date of Injury   28b. Time of Injury   28b.	28d. Describe how 28f. Location (Str. City or Town,	eet and Number or Rural Route Number,
Pours Pours Py filled Cal C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place of the complex of the complex of the basis of examination and/or investigation, in my opinion, death of and manner stated.		
To the He within 24 To the Fe complete	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Month, Day, Year)
C	Theoly M. Kry my O.C.M.E.		SEPTEMBER 15, 1998
8	30. Neme and eddress of parson who completed cause of death (ttem 23a) (Type, Print)		
	31. Date filed (Month, Day, Yeer) 32. Registrer's Signature	ltimore, Ma	aryland 21201
State Registrar	SEP 181998 Seres B. Sparks		



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day MASSDIN Softember 13 1847 124 Am 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) SINAI HOSPITAL BALTIMORE If Undar 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Yeer) If Under 1 Year 5. Social Sacurity Number 6. Sex 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) 1 ₩ M 2 □ F Months Days 165-14-2973 Yrs. 86 04/06/1912 Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits N/A Baltimore 1 Ves 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3819 Ridgewood Avenue 21215 U.S.A. 12. Was Decedant Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14 Baca - American Indian Black, Whita, etc. 1 Yas 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: Black 3½ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) MTA College (1-4or 5+) Mechanic 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alexander Massdin Arlantie Brittingham 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Sharon Sacaza 3819 Ridgewood Avenue, Balto., MD 21215 20b. Placa of Disposition (Name of cematery, cramatory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Buriai 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park9/18/98 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVENUE, BALTO., MD ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximete fnterval Between Onset and Death Immediata Cause (Final disease or condition resulting in death) testinal Bleeding Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algniffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 25 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 TRo 1 ☐ Yes 2000 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending

Examiner Examiner physician and the bunal-thansit The lew requires that the death certificate be asscuted Division of Vital Records, P.O. Box 68760, 980 signed by the a should certificeta has b or Attending Physician: director. this funaral death. after deat 24 hours after Funeral Dire letaly filled in b To the Hosp within 24 hor To the Fune completaly fi

**Physician** 

/Medical

Examiner

MD

**Funeral** 

Director

rai', or itams 23a or 28a-f show Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after death v Department of Health and Menlel Hyglena. Important: if Itam 27 is marked other than "natural", or frame 23a any injury or other traumatic avent, the Med

**Physician** 

/Medical

Saltimore, Maryland 21215-0020

Director

Funeral

by

Completed

the Maryland

with

Physician/Medicai g Completed Be To Certification:

edical

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Menner of Deeth 1 Natural 2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

investigation 6 Could not be determined

1 Yes 2 No 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

SINAI HOSPITAL

Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

SEP

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29d. Date signed (Month, Day, Year)

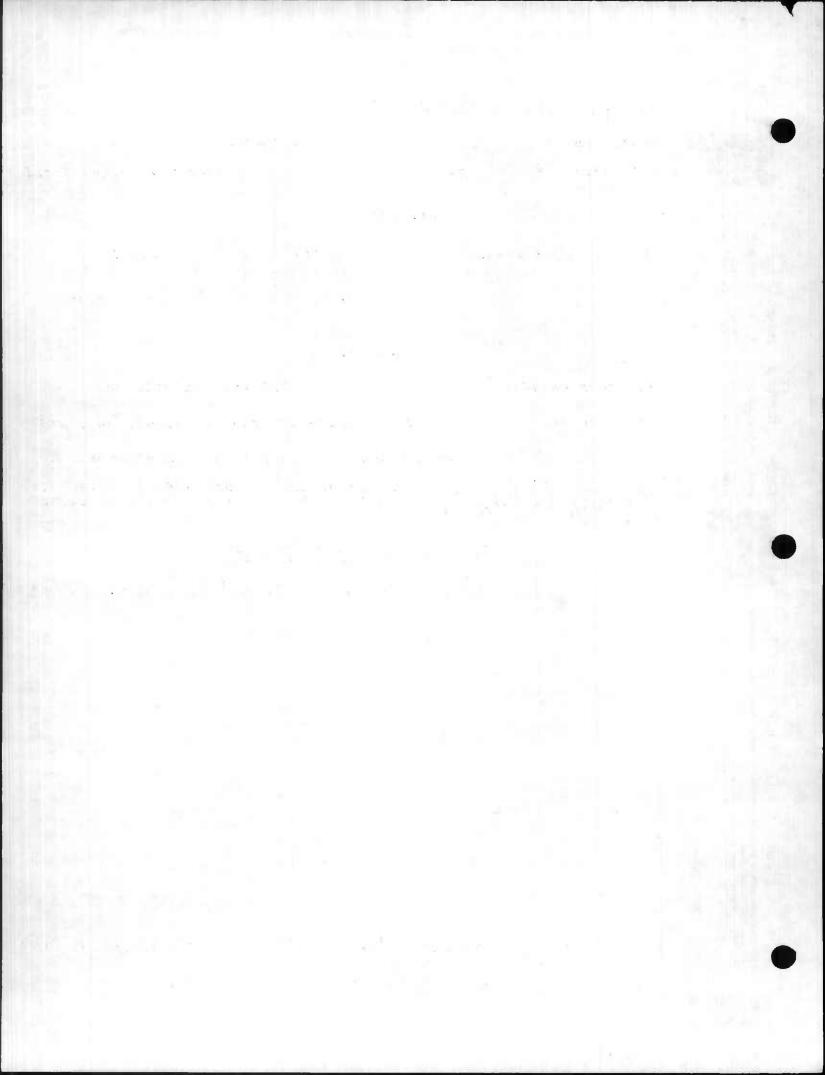
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

LANS MARIC FRYDENBORG 31. Date filed (Month, Day, Year)

1 8 1998

32. Registrar's Signatura Energy.

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 19b per F.H. G-763 9/18/98 reb Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** Sylvia Myers 5:45A /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hospital Prince George's Regional Laure Laure If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Dec. 26, 1913 9. Birthplace (State or Foreign Country) West Virginia **Funeral** Days 1 ☐ M 2 💢 F 218-18-1868 Dec. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or hems 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Howard Maryland Fulton 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 20759 P.O. Box 387 USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11 Marital Status 14. Race - American Indien, Black White etc. 72 hours efter 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed w.
Department of Haaith and Mental Hygiens important: if Nem 27 is marked other tha any Injury or other traumatic acceptances. Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Richard Ashby Davis Maggie Lena Dasher 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code)
8234 Slippery Rock Way, Laurel, Maryland 20723 Kenneth Myers/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State
4 ☐ Donation 5 ☐ Other (Specify) John's Lutheran Cem. 8/19 Columbia, Maryland of Funeral Service Licen 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 ar the mode of dying, such as cardiac or respiratory errest,

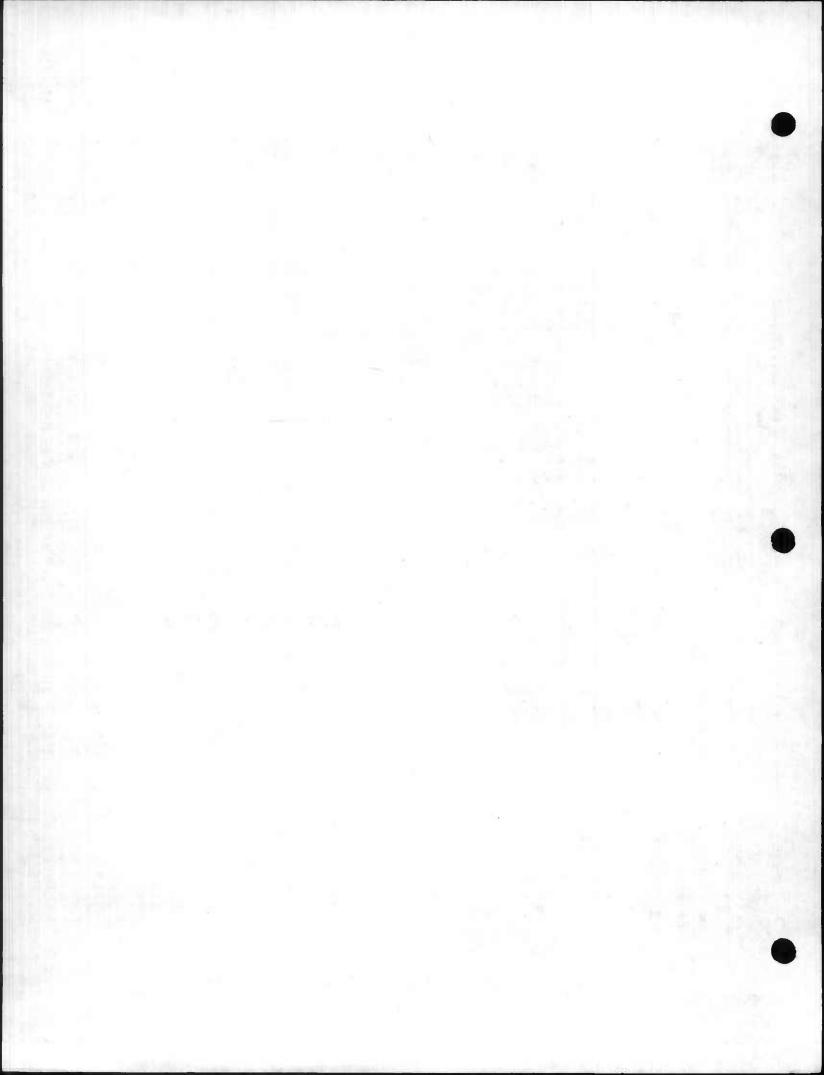
Approximate Intervel Between Onset and Death complications that caused the deeth. Do not enter **Physician** CONGESTUE CARDIOMYOPATRY Immediate Ceus (Final disease or condition resulting in death) /Medical Examiner MVOCARMIAL TWEARCHON Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest (or es a consequence CARDOVASIVUMA DITEASE MOUTH P.O. Box 68760, Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 No Division of Vital Records, þ 24b. Were autopsy findings available prior to Completed 24a. Wes an eutopsy performed? completion of cause of death? paga 2 s 2 10 No 1 ☐ Yes 2 No 25. Wes case referred to medicat examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funarai 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Attending 1 Natural 5 Pending Investigation death. 1 Tyes 2 No Director: A 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 24-hours after 4 Homiclde 6 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie 29c. License numbe 29d. Date signed (Month, Dey, Year) completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 16 Rev 6/95

State

32. Registrer's Signeture



State of Mandand / Department of Health and Montal Hygiana

State of Maryland	17 Department of Health and			-		
	Certificate of Death	Reg. No.	21	86	5 5	1
ast)		2. Dete of Deeth Month Dey Year			Time	

	Н
Physician	ı
/Medical	
Examiner	ľ
	ı

4a Facility Name (If not Institution, give street and number)

Birthplaca (Steta or Foreign Country)

10d. Inside City Limits

1 Yes 2 □ No

Maryland

**Funeral Director** 

the Maryland

Director Funeral by Completed

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be not ited and once. Baltimore, Maryland 21215-0020

**Physician** /Medical Examiner

Physician/Medical Examiner and certificate be execu physician a the burtal-Division of Vital Records, P.O. Box 68760, 10 8 96 signed by t d be detact Completed certificate Be Certification: To this Attending Dire b

à

edical

1. Decedent's Nama (First, Middla, L. September 16, 1998 1:14 P.M. Cornelius Anderson Myers 4b. City, Town, or Location of Death 4c. County of Death 2305 Maryland Avenue, Apartment 520 Baltimore N/A If Undar 1 Yaar | If Under 24 Hrs. 8. Defe of Birth (Month, Dey, Year) SEP 3, 1958 5. Social Sacurity Number 7. Age (In yrs. last birthday) 6. Sex Months 1 M 2 □ F Deys Hours 215-70-6754 Yrs. 40 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location MD N/A Baltimore 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? 2305 Maryland Ave., Apt. 520 21218 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No ff Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indian. Black, White, etc. 1X Navar Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Dietary Aid Nursing Home 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Nama (First, Middle, Last) Junius Craten Myers Edith Devilbliss Conner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Joyce L. Leake/sister 1665 NorthBourne Rd. Baltimore, MD 21239 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cremetion 3 Ramoval from State Metro Crematory, Inc. 19/17/98 Baltimore, 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Puneral Service License 22. Neme and Address of Facility
Cremation Society of Maryland, Inc. Edward Gregorchik 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Entar the disease, or complications that caused the death. Do not enter tha mode of dying, such as cerdiac or respiretory errest, shock, or haert feilura. List only one cause on each line. Immediete Ceuse (Finel disease or condition resulting In death) " END SLUCTE KIDNEY DIZEUSE AND REDNICED IMMUS DEPICIENCY SYNDROWS Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enfer Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest

Due to (or es e consequence of)

Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert f.

23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown

1 Yes 2 100

Approximete Interval Batween Onset end Deeth

24e. Wes en eutopsy performed? Duspoon

24b. Were eutopsy findings evelleble prior to completion of ceuse of deeth?

2 No 1 Yes

1 ☐ Yes 2 ☐ No

25.	Was case	referred	to	medice
	exeminer?			
	TY Yes	2 No		

27. Menner of Deeth 2 Accident

3 ☐ Suicide

4 Homicide

5 Pending invastigation 6 Could not be determined 28a. Date of fnjury (Month, Dey Year)

1 ☐ Inpatienf 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of

28e. Place of fnjury - At home, farm, street, factory, office building, atc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

111 Penn Street, Baltimore, Maryland 21201

28d. Describe how Injury occurred

Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Dete signed (Month, Dey, Year)

Monte

O.C.M.E.

September 17, 1998

30. Neme and eddrast of person who completed cause of death (Item 23e) (Type, Print)

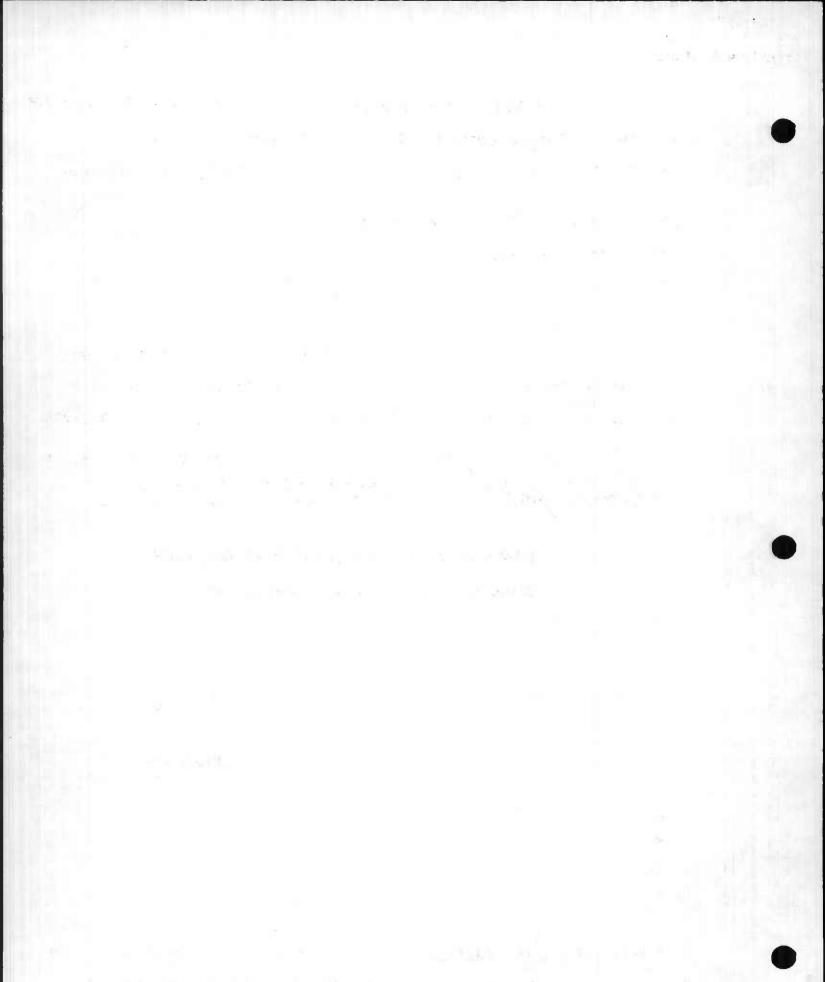
MARYAMON A
31. Date flied (Month, Day, Year)
SEP 181998

KORFU VID. 32. Registrer's Signeture

State Registrar

24 hours Funeral

To the Within 2 To the



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth September 17 WILLIS E. MERSON 11:01 1998 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE UNION MEMORIAL HOSPITAL 5. Social Security Number 578 16 1304 if Under 1 Year 8. Dete of Birth (Month, Day Year) Sept. 09 1911 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) **™** M 2□ F 87 Months Deys Hours Maryland Yrs Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No n/a Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21230 USA 1522 Belt Street 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Black, White, etc. 1 X Yes 2 □ No WWII If Yes, Give Year or Dates: 1 Never Married 3 Married 1 ☐ Yes 2 ▼ No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) Warehouse Foreman 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Lina Bellison Harry Merson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Grace E. Merson (Wife) 1522 Belt Street, Baltimore, Md. 21230 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Sept. 19 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State Damascus, Md. Montgomery Cemetery 4 Donetion 5 Other (Specify) 21. Signature of Foneral Service Licensee McCully-Polyniak 130 E. Fort Ave. Funeral HOme Baltimore, Md. 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death fmmediete Ceuse (Finei disease or condition resulting in deeth) Arter Colonary Due to (or es e consequence of) Diasetes Mellitus Due to (or es e consequence of): Due to (or es e consequence of) 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No

**Physician** /Medical Examiner

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2 signed t

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After

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n 24 hour.

within 2 To the

Box/88760.

Division of Vital Records, P.O.

Hospital or Attending Physician:

Examine

Physician

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Completed

Be

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Certification:

Medical

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

**Funeral** 

Director

the Manyland

permit. Peges 1 and 2 should be filed within 72 hours effer death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or fleme 23a or 28a-f show any highry or other traumetic event, the Medical Examinat must be notified at once.

altimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Pert II. Other afgniffcent conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 KInpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28d. Describe how injury occurred

27. Menner of Death 1 Natural 2 Accident 3 Suicide

28e. Dete of Injury (Month, Day Year) 5 Pending Investigation 6 Could not be determined

28b. Time of 28c. Injury et Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

4 Homicide 29e. Certifier (Check only one)

1🗹 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner es stated. 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier

29c. License number

29d. Dete signed (Month, Day, Year)

AT 2438946

9-17-98

28f. Location (Street end Number or Rural Route Number, City or Town, State)

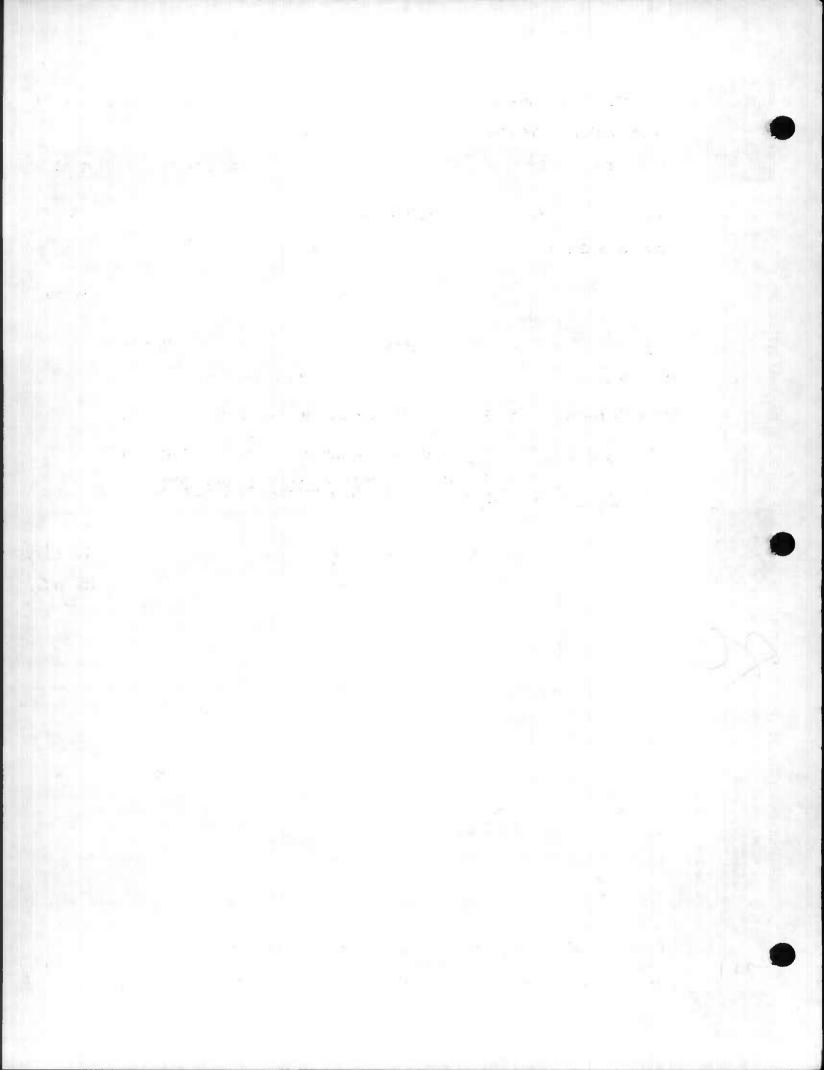
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

NEGRINI, HD 201 EASTUNIVERSity Parkway

BALTIMORE MD 21218

Registrar

31. Date filed (Month, Day, Year) 8 1998 32. Registrer's Signature



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Q Month Dev 4b. City, Town, or Location of Deeth 4c. County of Deeth FRANK WALTER MACHOVEC 4e Fecility Neme (If not institution, give street end number) Baltimore Sedale 10 If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) Franklin Square 5. Social Security Number 16. Sex 7. Age (In yrs. last birthday) HOS If Under Birthplace (Stete or Foreign Country) Months Days 1XM 2□ F 213-01-4741 81 SEPT. 14, 1917 MD. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No MD. BALTIMORE 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 2210 CORBIN ROAD 21214 U.S.A. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Biack, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 YRS POLICEMAN BALTIMORE CITY 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) KATHERINE SCHAFFER FRANK MACHOVEC 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 2210 CORBIN ROAD BALTIMORE, MD. 21214 VIVIAN MACHOVEC/WIFE 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State OAK LAWN CEMETERY 9/19/98 BALTIMORE CITY 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signety of Funerel Service Licensee 22. Name and Address of Fecility CHARLES S. ZEILER & SON, RRI un 6224 EASTERN AVE. BALTIMORE, MD $_{\mbox{\tiny H}}$ enter the mode of dying, such as cerdiac or respiratory errest, 21224 Approximete 23a. Pert1. Entrit the disease, or complications that caused the death. Do not enter shock, or next failure. List only one ceuse on each line. Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) oronary tery etes Diab e Due to (or es e consequence of): 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of ceuse of death? 24e. Was en autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28b. Time of

**Physician** /Medicai Examiner

Division of Vital Records, P.O. Box

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Director

Funeral

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Was cese referred to medicel examiner?
1 ☐ Yes 2 No 27. Manner of Death

5 Pending Investigation 1 Netural 2 Accident 3 Sulcide 6 Could not be 4 | Homicide

SEP 1 8 1998

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) and manner as steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) end manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number

29b. Signeture and title of certifier

completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

Drive Baltimore, Maryland 21237 arco 31. Dete filed (Month, Dey, Year 32. Registrar's Signature

State Registrar

Completed

Be

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Certification:

edical

29e. Certifier

(Check only one)

page 2

certificate

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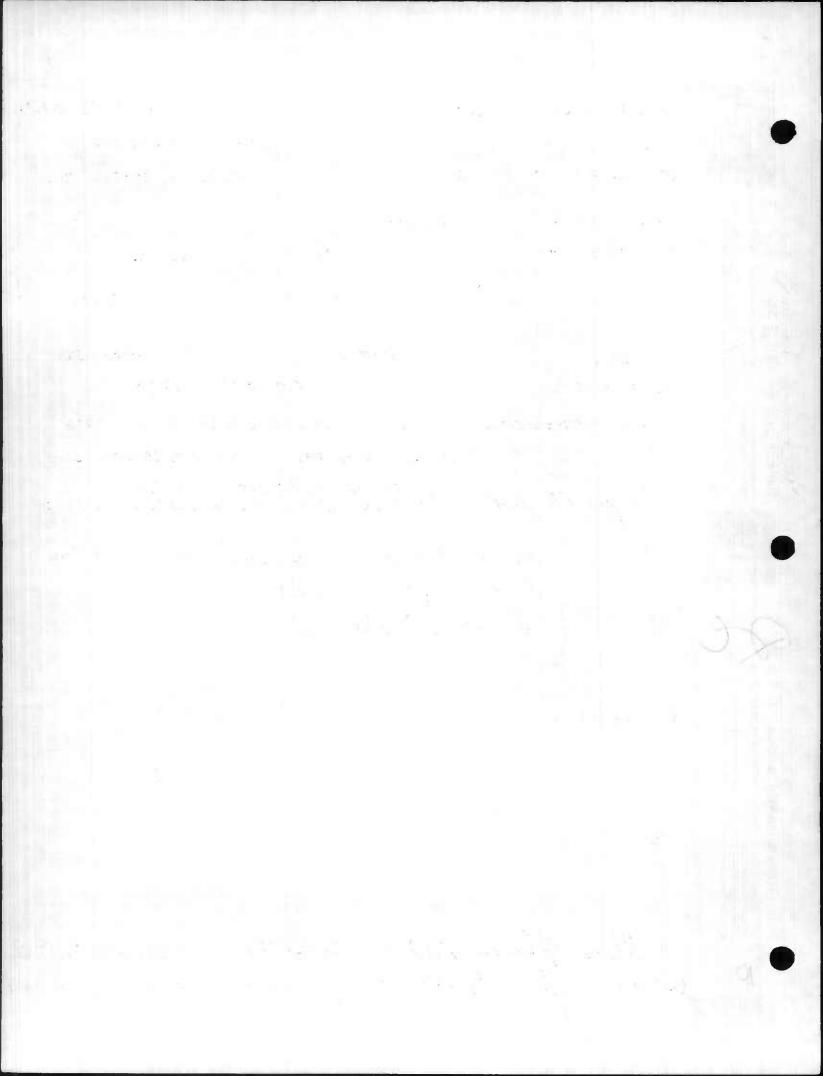
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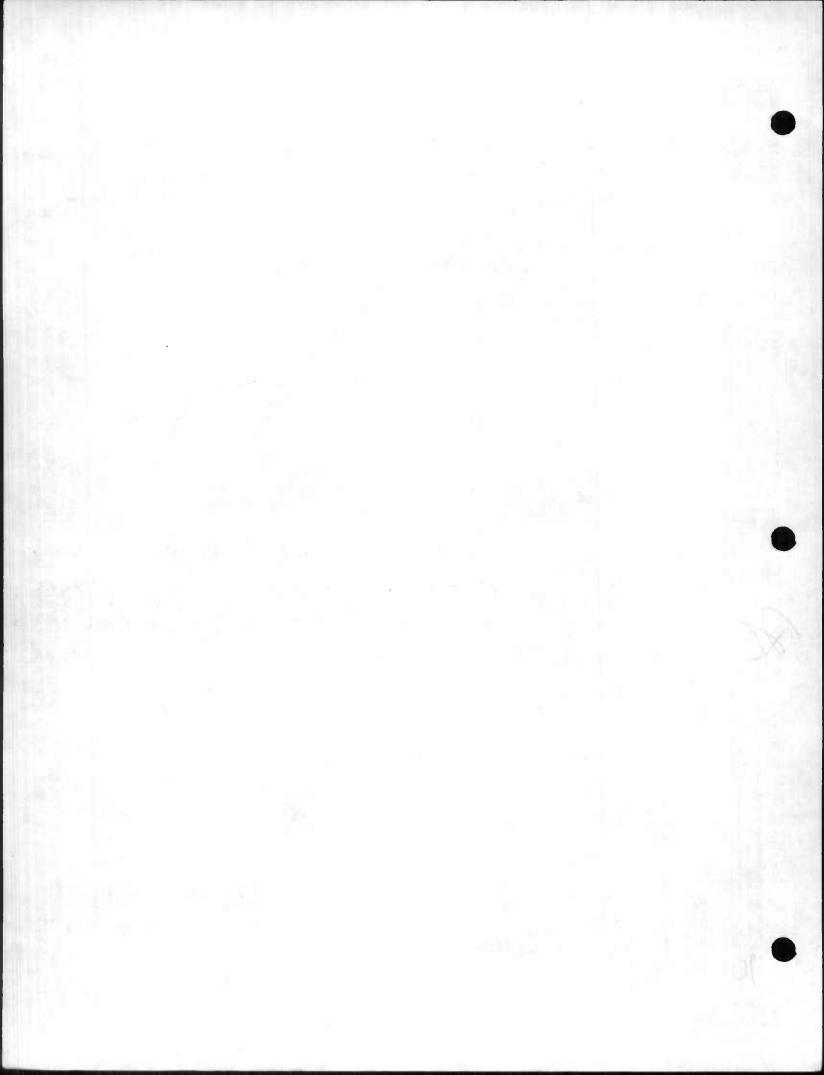
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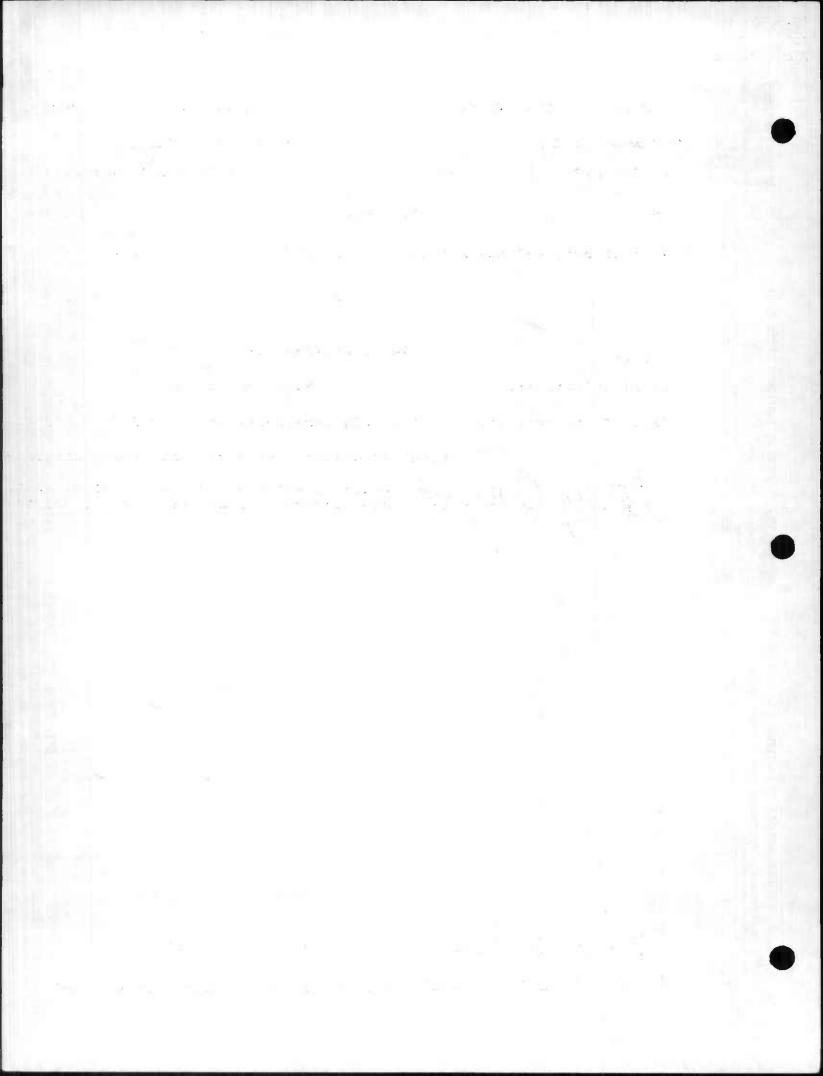


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year September 15 1998 **Physician** Robert Leroy Middleton 4:30 am /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Pleasant Living Convalescent Center Edgewater Anne Arundel 5. Social Security Number If Under 1 Yea 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 100M 20 F Months Days Hours 576-38-2190 Director 83 Sept. 27, 1914 Maryland Usual Residence of Deceden 10a Stete 10h Counts 10c. City. Town or Location 10d. Inside City Limits 28a-f show Anne Arundel MD Edgewater 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 305 Millswamp Road 21037 USA "natural", or items 23a Funeral 14. Race - American Indian, Black, White, etc. 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or Nott Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Merried 25 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White A 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiena. Important: If Nem 27 is marked other than "naturally injury or other traumatic event any injury or other traumatic event." 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Officer US Navv 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert George Middleton Blanche King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Barbara Warren Middleton-Wife 305 Millswamp Road, Edgewater, MD 21037 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Cemetery 9/21/98 Davidsonville, MD 21. Signature of Funeral Service Licens 22. Name end Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** tmmediete Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Physician/Medicai thet initieted events resulting In death) Last Box for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Was an autopsy performed? 24b. Were autopsy findings Completed available prior to completion of cause of death? page 2 1 Yes 2 No this certificate Division of Vital 25. Wes case referred to medicat exeminer? 8 26. Piace of Deeth (Check only one) 1 Yes 2 No Other: Certification: To 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Neturel 5 Pending investigation a Funeral Director: Aft bletchy filled in by the fur 2 □ No 1 Yes 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 | Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. edicai 29a. Certifier completely (Check only one) within 2 To the F To the 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Forest 31. Date filed (Month, Day, Year) 32. Registrer's Signature State SEP 1 8 1998 Registrar



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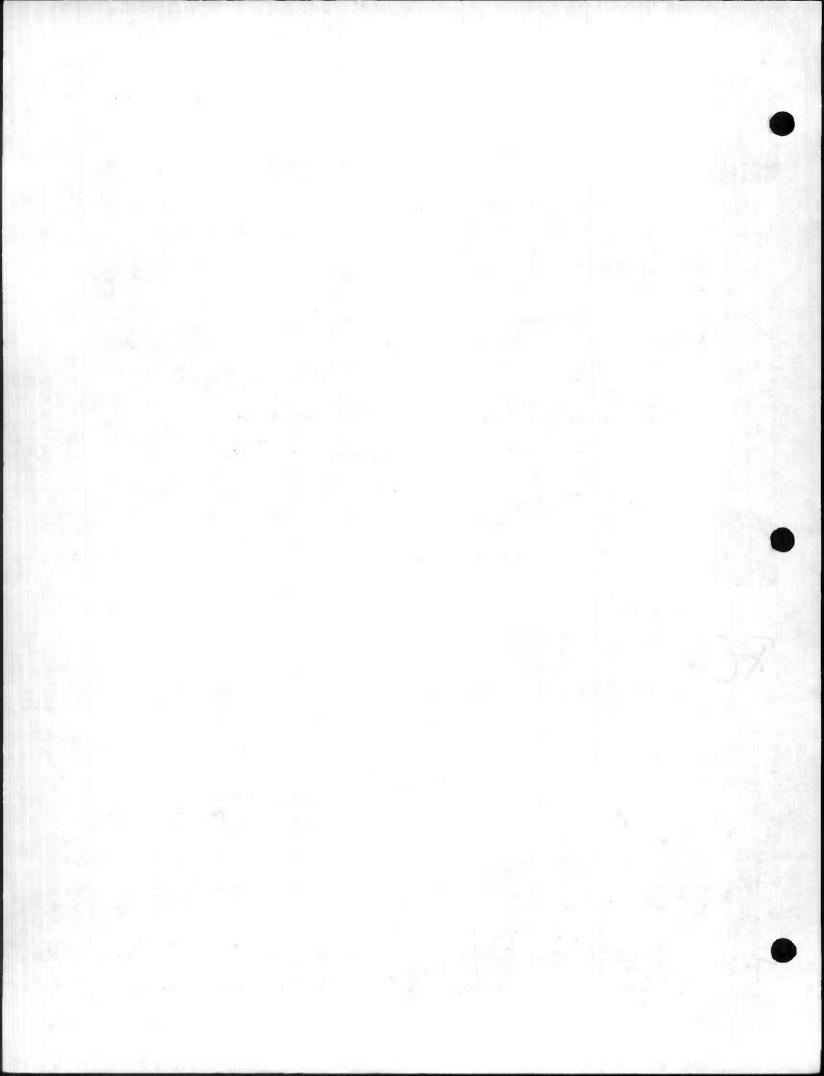
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 14 1998 11:00 PM **Physician** JOHN J. NORRIS /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/A 1412 BATTERY AVE. If Under 24 Hrs. Hours | Min. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 8. Dale of Birth (Month Day, Year) May 03 1926 9. Birthplace (State or Foreign **Funeral** Deys 100M 20F Months Mary land 220-18-5300 72 Director Usual Residence of Decedent Manylend 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumedic event, the Medical Examiner must be notified at Baltimore Md. n/a 1X Yes 2 No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò deeth with 21230 USA 1412 Battery Ave. 23a Funeral Nerns : 12. Wes Decedent Ever in U,S. Armed Forces?

1 XYes 2 No If Yes, Give 1 943-46 Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Stetus permit. Pages 1 and 2 should be filled within 72 hours effer c Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or iten any injury or other treumatic event, the Medical Egyptical Contract. Black, White, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: white Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) U.S. Government Postal Clerk 18. Mother's Name (First, Middle, Maiden Sumame)
Jennie Sturgeon 17. Fether's Neme (First, Middle, Last) Be John E. Norris 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 304 15th Ave. Baltimore, Md. 21225 19e. Informent's Neme/Reletionship (Type, Print) Debra A. Airey (Daughter) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece)
Glen Haven Memorial Pk. Sept. 17 20a. Method of Disposition 20c. Location - City or Town, State 1 X Buriel 2 Cremetion 3 Removal from State Glen Burnie, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Servica Licansee McCully-Polyniak Funeral Home 130 E. Fort Ave. Baltimore, Md. 21230 lline 23e. Pert1/Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear fellure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediete Cause (Finel diseese or condition resulting in deeth) colon ears Examiner Due to (or as e consequence of): Examine Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): 68760 Physician/Medical thet initiated events resulting in death) Last Due to (or es a consequenca of): Box The law requires that the de-Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23h. Did tohacco use contribute to the cause of death? Division of Vital Records. P.O. 2/X No 1 □ Yes 3 Probably 4 Unknown pe det þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy performed? No No or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Placa of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Neturel r death. 1 Yes 2 No 2 Accident biter death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 4 Homlcide Hospital 24 hours Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner steted. 29a. Certifier (Check only one) within 2 To the I the th 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 20 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) ltimore Manyland 5 Elizabeth Claire Dees 600 Northwoll

State Registrar

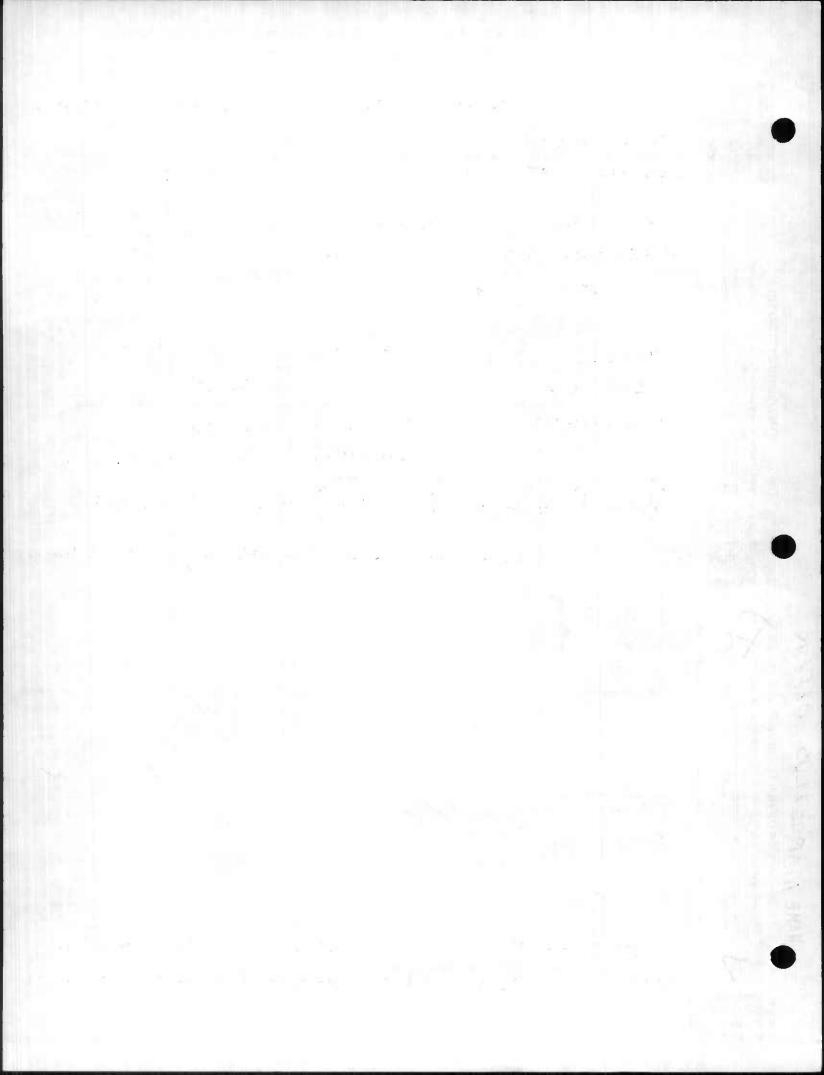
32. Registrer's Signeture



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

aio.	1.	Decedent's Nam	e (First, Middl	le, Last)		2.2							2. Date of D	eath Da	ay	Year	3. Time o	Deeth
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iner	40	St Agne		-		ium <i>ber)</i>					Baltin		cation of Dea		o. County	of Death		
	5.	Social Security N		pit 6. Sex		7. Age (	In yrs. le	st birthday)		er 1 Year	If Under 2	24 Hrs.	8. Date of B (Month, D		N/A	9. Birthp	lace (Stete	r Foreign
	-	213-32-68		11/	2 F	57		Yrs.	Months	Days	Hours	Min.	1-29	-194	1	Coun	Md Md	
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2	L	Md	N/	'A			Ва	altimo										2 No
Dire	10	9e. Street and Nu		Δ,	venue					ip Code 2122	q				itizen of V	What Coun Λ	try?	
5	11	I. Marital Status	ionason		12. Was De	cedent Ev	er in U.S	13 1				nin? (Sne	cify Yes or N			a - Americ	an Indian.	
To Be Completed by Funeral Director	•	1 Never Marr 3 Widowed		ried	Armed F	Forces? 2 No Sive	0, 0, 0,0		If Yes, spo 1 ☐ Yas			, Puerto	cify Yes or N Rican, etc.)		Blac	k, White, o	etc.	
		15. Decedent's Education (Specify only highest grade complated)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired)				16b. Kind of Business		usiness/Ind	lustry				
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth September 13, 1998 Month **Physician** Catherine Jeanne Orth 6:15 p.m. /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fallston General Hospital Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) **Funeral** Min 1□M 2₽F Months Davs Hours 216-20-4094 Director August 5, 1926 Baltimore City, Mil Usual Rasidanca of Decedent the Marylend 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Harford Fallston 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? permit. Peges 1 end 2 should be filed within 72 hours after death with 1 Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "naturel", or itema 23a or i any Injury or other traumatic event, the Medical Examiner must be n 2812 Beechwood Lane 21047 Funeral USA Raca - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Mentel Status Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Account Receivable Manager Reliable Stores 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) Be James Henry Hughes Mary Theresa Cawley 19a. Informant's Neme/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George P. Orth (Husband) 2812 Beechwood Lane Fallston, Maryland 21047 20b. Plece of Disposition (Neme of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other pleca)
St. John's Catholic Cem. 1 ☐ Gurial 2 ☐ Cremation 3 ☐ Removel from State September 16,1998 Long Green, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
E.F. Lassahn Funeral Home, P.A. ature of Funeral Service Licensee 11750 Belair Road Kingsville, Maryland 21087-1351 Do not enter the mode of dying, such as cardiac or respiratory arrest, ase, or complications that cause. List only one cause on each Approximata Interval Between Onset end Deeth **Physiclan** static Caravanad the Bladder /Medical Immediate Cause (Final Several disease or condition rasulting in death) Examiner montes Examiner Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Causa (Diseasa or Injury that initiated events resulting In death) Last Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): USB BS Part II. Other significant conditions contributing to death but not resulting in the undarlying causa givan in Part i. 23b. Did tobacco use contributa to the causa of death? been signed by the should be datached 1 Yes 2 No 3 Probably Anknown by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Completed page 2 1 Yes 2 No 1 Yas certificate Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Placa of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yas 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 27. Manper of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending invastigation 1 Matural aftar death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be detarmined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 D Homicida To the Hospital within 24 hours a To the Funeral Completaly filled 1 Certifying Physician: To the best of my knowledga, death occurred at tha tima, data and place, and due to the cause(s) and mannar as stated.

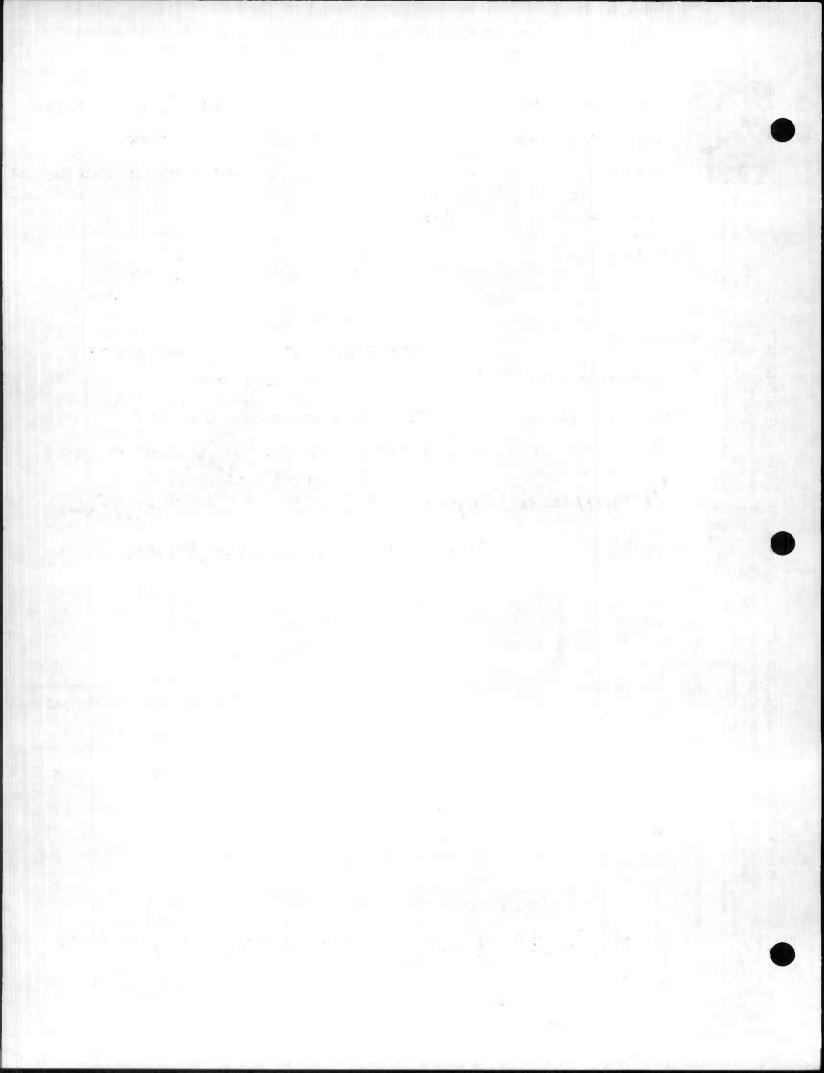
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifiar Medical 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 30. Name and address no completed causa of death (Item 23a) (Type, Print) GENERAL 1405P

State Registrar FRE

32, Registrar's Signature

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31. Dete filed (Month, Dey, Year)



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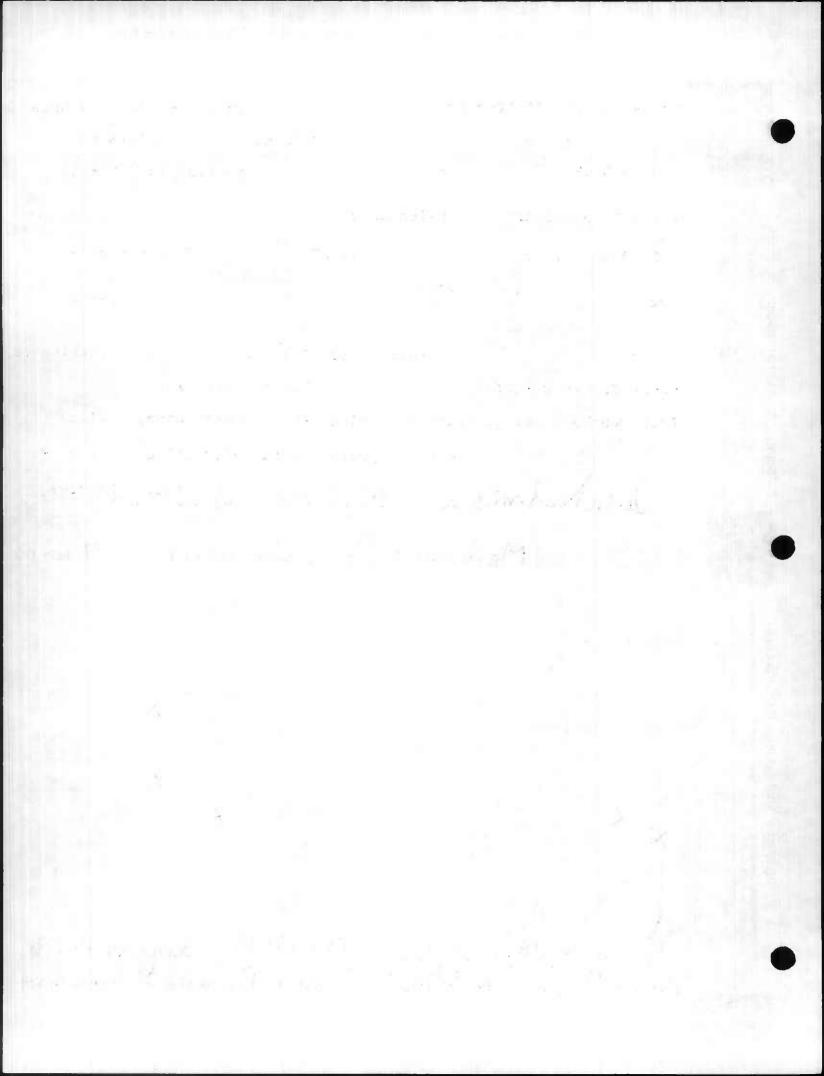
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Henry Joseph Pfieffer Jr. 16, 1998 4:00pm Sept. /Medical 4a Facility Name (If not institution, give street and number) 4b. Cltv. Town, or Location of Death 4c. County of Death Examiner Baltimore 4304 Ridge Avenue Halethorpe | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Form (Month, Day, Year) | 7 | Maryland 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 1 M 2 □ F Months 214-20-6359 Yrs. 70 Director Usual Residenca of Decedent Pagas 1 and 2 should be filed within 72 hours after death with the Meryland nent of Health and Mental hygiena.

Int: If Item 27 is marked other than "natural; or items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notified at 10a State 10h County 10c. City, Town or Location 10d. Insida City Limits Baltimore Halethorpe 1 ☐ Yes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21227 4304 Ridge Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? DYSES 2 □ No 6/45 If Yes, Give Year or Dates: 8/46 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: þ white 3℃Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) Collaga (1-4or 5+) Liquor Distributor Merchandise Displayer 8 18. Mothar's Name (First, Middla, Maidan Sumame) 17. Father's Name (First, Middle, Last) Be Grace Louise Tucker Henry Joseph Pfieffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anna Dougherty, sisterinlaw 4302 Ridge Avenue Halethorpe, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State Good Sheppard Cemetery9/19 Ellicott City, MD 1 □XBurial 2 □ Cremation 3 □ Removal from State Depertment of Important: If any Injury or page. 4 Donation 5 Other (Specify) 21 Signature of Funeral 22. Name and Address of Facility Ambrose Funeral Home, Inc. Arbutus 1328 Sulphur Spring Road Maryland21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or haart failura. List only one causa on each lina. Approximate Interval Between Onset and Death **Physician** THEARS /Medical Immediata Causa (Final ASTATI disease or condition resulting in death) Examiner Examiner physician end the burief-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical Due to (or as a consequenca of): 98 esn ŏ signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 740 3 Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? aw page 2 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: director. 25. Was casa referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1□ Yes No 2 1 | Inpatient 2 | ER/Outpatient 3 | DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Dascribe how Injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation efter deeth. 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homiclde 24 hours e Hospital 29a C etifier 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to tha causa(s) and mannar as statad. To the Hosp Within 24 hor To the Fune completely fi Medical or: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 296 29c. Licensa number 29d. Data signad (Month, Day, Year) DEPTEMBER 17, 1998 30. Name and addrass of perso m 23a) (Type Print) DANTHORE ALALL ATON WENTE 001 1484LAND 313-39 31. Date filed (Month 32. Registrar's Signature State

**DHMH 16 Rev 6/95** 

Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month SEPTEMBER 16, 1998 City, Town, c. OLLINGE If Undar 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 4e. Fecility Name (If not institution, give street and numbar) 4b, City, Town, or Location of Death 4c. County of Death HOSPICE B. Sax 5. Sociel Sacurity Number 7. Aga (In yrs. lest birthdey) If Under 1 Year Birthplaca (State or Foreign 212-02-8453 10 M 20 F Months Deys Yrs. Tary Usual Residenca of Decedant 10b. County State 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Hrundle 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 12. Wes Dacedant Ever in U,S. Armed Forcas? 1 Yes 2 DNo If Yes, Give Yeer or Detes: 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - American Indien Black, White, atc. 1 Navar Married 2 ☐ Marriad 1 ☐ Yes 2 ☑ No Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 17. Fether's Neme (First Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Galloway Juner nandre 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20b. Piece of Disposition (Nama of Mothe Hark 20a. Method of Disposition 20c. Location - City or Town, Stete Dete cematery, cremetory or other place 1 Buriel 2 □ Cremetion 3 □ Ramovel from Stata Memorial 4 ☐ Donetion 5 ☐ Other (Specify) MARQUIS lork 22. Name and Addrass of Facility HICKS FYNERAL Signatura of Funeral Sarvice Licensee 23e. Pent. Effer the diseasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock or heer feiture. List only one ceuse on each line. Approximete Intervel Between Onsat end Death Immediete Ceuse (Finei disease or condition resulting in death) 11 months Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events rasulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequença of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 🗆 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evaileble prior to completion of cause of deeth? 24a. Was en eutopsy performed? 20 No 1 Tes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) MARIS AT MERCY Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSDICE 25/No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Magner of Deeth Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

Box 68760, The law requires that the death certificete be Division of Vital Records, P.O. or Attanding Physician: **Physician** 

/Medical

Examiner

**Funeral** 

Director

or items 23a or 28a-f show

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Pages 1 and 2 should be nent of Heaith and Mental

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29a. Certifier (Check only

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altimore, Maryland 21215-0020

certificate hes After this death.

• Funeral Director: A Petely filled in by the f the within 2 To the I Tot

State Registrar

FERNANDO 1. 31. Dete filed (Month, Day, Year) SEP 1 8 1998

29b. Signature and titla of certifier

FERRO MO 32. Registrer's Signeture

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30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)

3x/to

Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, deta and place, end dua to the cause(s) end menner stated.

29c. Licansa numbar

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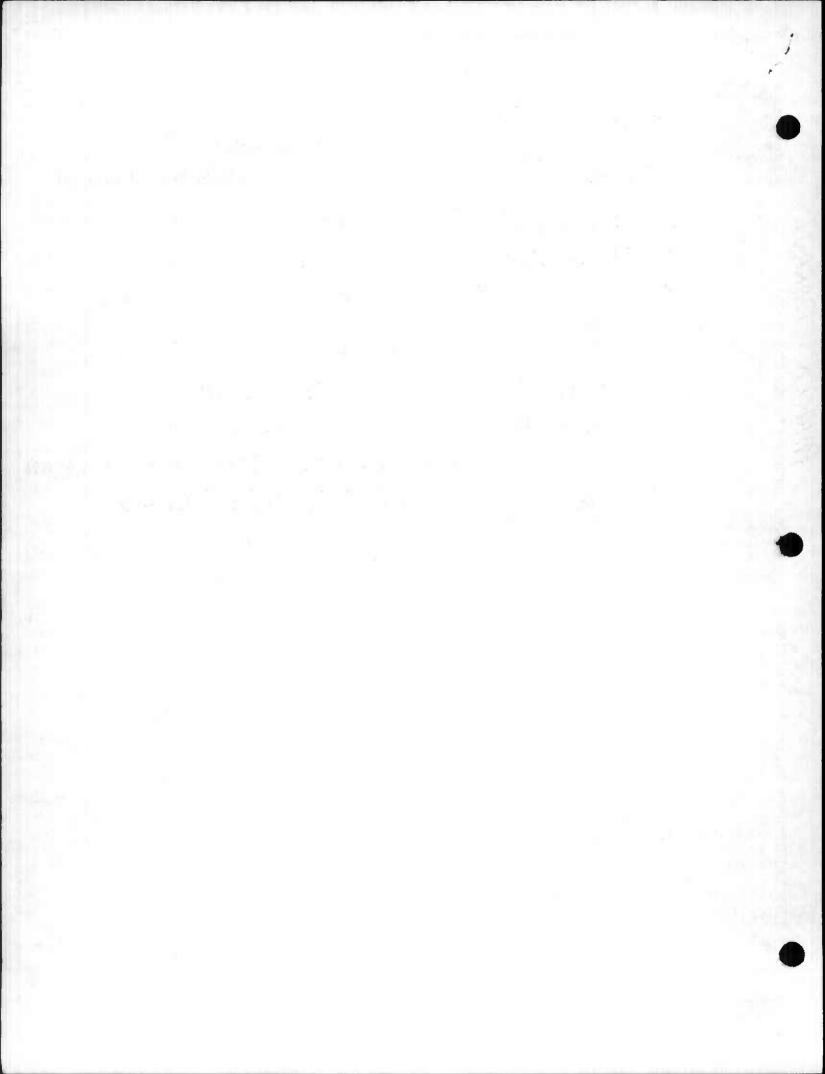
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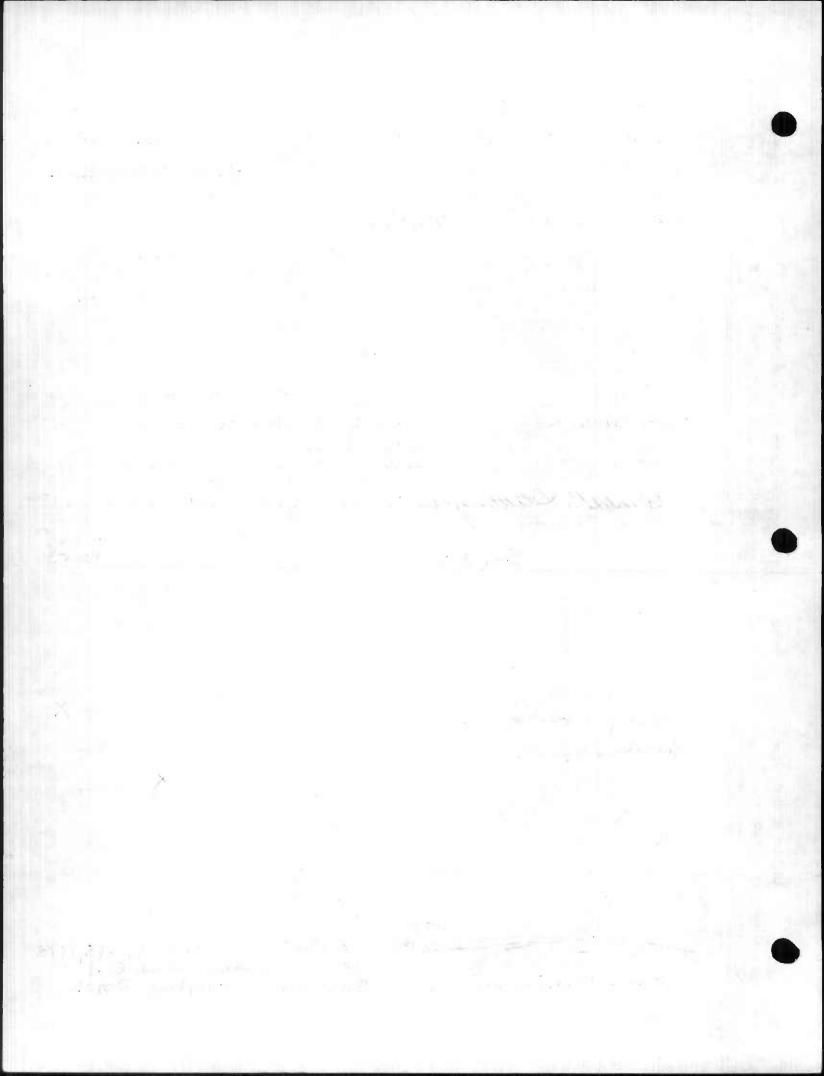
**DHMH 16 Rev 6/95** 



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 8 28667

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Physician /Medical	SADIE	PRUSSIN				Month Septem	ber 13,	Year 1998	5:35 AM
Examiner	4e Facility Name (If not institution, gi	ve street and number)			4b. City, Town,	, or Location of Deat	4c. County	of Death	
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P	Usuel Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or	Location				10	0d. Inside City Limits
the Maryland 28=4 show notified at	Manual and Manager								1 XYes 2 No
with the Ma or 28s-f e	Maryland   Montgom	ery	Silver	Spring 101. Zip Code			10g. Citizen of	What Count	to/2
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fer death virtue 234	11. Merital Status	12. Was Decedent Ev	er in U.S. 13			? (Specify Yes or No		e - America	an Indien,
urs effer	1 Never Merried 2 Married	Armed Forces?  1 Yes 2 XNo If Yes, Give Year or Dates:		If Yes, specify Cu 1 ☐ Yes 2 ② No	ban, Mexican, P	ruerto Rican, etc.)	Specif.	ck, White, e	nite
1 21215-002 ed within 72 hours tygiene. For then "natural; It, the Medical Completed by	15. Decedent's E		16a. Dec	sedent's Usual Occ	upation	Lundring	16b. Kind of B	usiness/Ind	iustry
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Maryland 2 should be flie th and Mental Hy 7 le merked oth treumatic event To Be (	19a. Informent's Name/Reletionship	(Type, Print)	19b. Ma	iling Address (Stre		or Rural Route Numb		Stete, Zip	Code)
y N and 2 alth 27 I	Joanne Strauss, D	aughter				reenwich,	Connec	ticut	06831
Baltimore, Maryland permit. Pages 1 and 2 should be flied. Department of Health and Mental thy important: If item 27 is marked other event, and injury or other treumatic event, and.	20a. Method of Disposition	70	20b. Place of Disp	position (Name of	4F04)+	Date	20c. Location	City or To	wn, Stete
Maltimore, semit. Pages 1 at a speriment of Heam moortant: If Item in the line of the more in the more of the more.	1 ☑ Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Speci			ion Ceme		17/1998	Fairfie	14	CT
Porting.	21. Signature of Funerel Service Lice	nsee		22. Name and Add	ress of Facility	ORIAL FUNI	TOTAL TOTAL		
DESE	DA ME	Street							D.C. 2001
/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	· Seps	ne to (or as a cons	equence of):				3 3 1	Hours
OX 68/60, certificate be executed vising physician and use as the buriel-fament	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initioted events resulting in death) Last	c	He to (or es a conse						
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0 5 5 5	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y		of 28c. Inj			how injury occur		
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To the Hospital within 24 hours. To the Funeral completaly filled	29a. Certifier (Check only one) 12 Certifying Pl	hysician: To the best of miner: On the basis of ex and manner state	amination and/or i	nth occurred et the investigation, in my	time, date and p opinion, death o	lace, end due to the occurred at the time,	cause(s) end m date and place,	anner as stand due to	ated. the cause(s)
within To the comp	29b. Signature and title of certifier	_			nse number		29d. Date signe	ed (Month, I	Day, Year)
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10	30. Name and address of person who	completed cause of dear	th (Item 23a) (Type	e, Print) 330°	5 Nort	h heisne	would	RIV	7,110
P	C. Ozanne-Blank	Ford mis	٠, , , , ,	Silv	- 5	is Man	1/9:1	200	306
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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month 10:00 AM rept (998 12 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth If Under 24 Hrs. 8. Date of Birth Min. (Month, Dey, Yeer) 9. Birthplece (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. lest birthday) If Under 1 Year Months 1 M 2 F Deys 219-26-1246 58 Yrs. Sept. 21 1939 Usual Residence of Deceden 10c. City, Town or Location 10d. Inatde City Limits 10a. Stete 10b. County Baltimore 1 Yes 2 No mp NA 10g. Citizen of Whet Country? 10f Zip Code 10e. Street end Number USA 3919 Maine 21207 12. Wes Decadent Ever in U,S. Armed Forces? 1 ▼Yes 2 No If Yes, Give 14. Race - American Indian, Bleck, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Meritel Status 1 Never Married 2 Married Specify: Specify: Black 3 Widowed 4 Divorced 18e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cotlege (1-4or 5+) Machine 11+h NA TRESSMON 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Ph. COOPER 40800 CONSUELO 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Balto. md. 21207 3919 Maine Ave. Reid-Frances TON: 20b. Placa of Disposition (Neme of 20c. Location - City or Town, Stete 20e. Method of Disposition Dete cametery, crematory or other place 1 Buriel 2 Cremetion 3 Removel from State Memorial Randallstown, mg Hart 9-18-98 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility March Funeral n of Funeral Service Licensee West, march 23a. Pert. Enter the riseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shoot, or human siture. List only one cause on each tine. Dalto. Approximete intervel Between Onset end Death immediete Ceuse (Finel diseese or condition resulting in death) a Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Due to (or as a consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 robably 4 Unknown 24b. Were autopsy findings aveileble prior to completion of cause of death? 24e. Wes en eutopsy 1 Ves 2 No 1 ☐ Yes 2 100 26. Piece of Death (Check only one)

/Medical Examiner pue Division of Vital Records, P.O. Box 68760

**Physician** 

signed by the

**Physician/M** 

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Certification:

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31. Dete filed (Month, Dey, Year)

**Physician** 

/Medical

Examiner

Director

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**Funeral** 

Director

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certificate funeral director.

or Attending Physician: effer death. Director: After this certific Hospital
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25. Wes case referred to medicat exeminer? Hospitat: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how tnjury occurred 28c. Injury et Work? 1 Neturel 5 Pending 1 🗆 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier

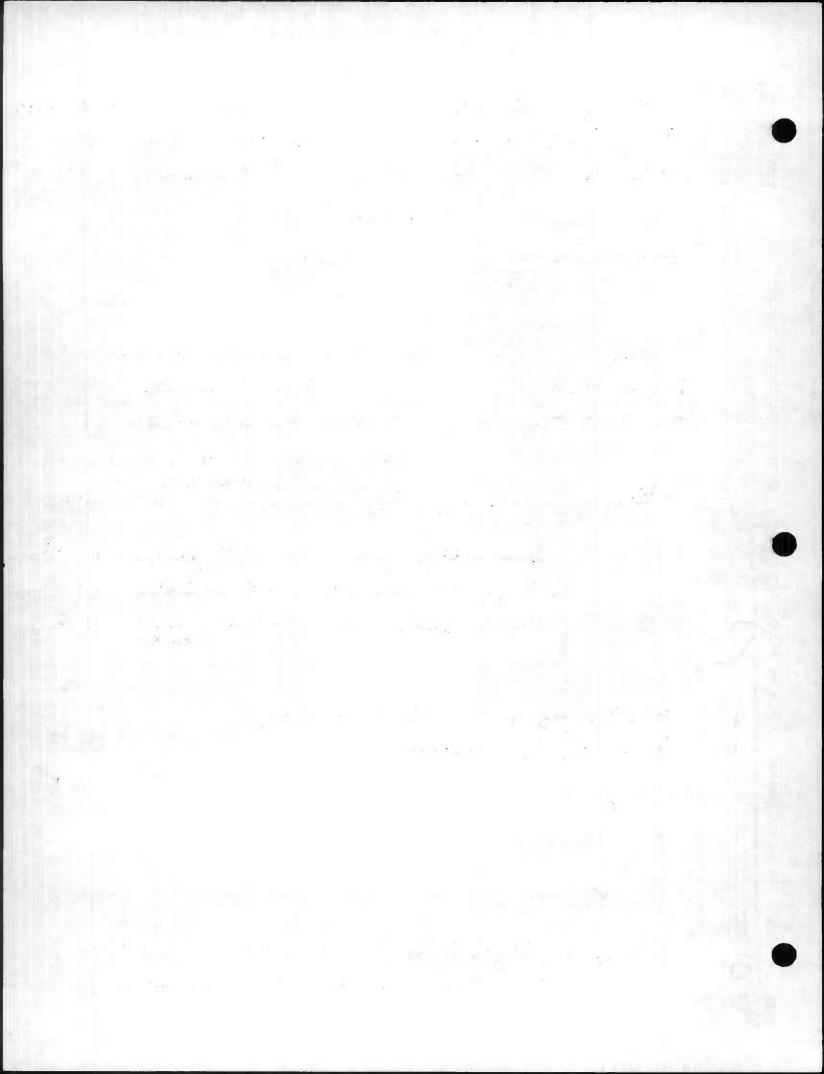
1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and placa, and due to the ceuse(s) end menner stated. (Check only one) 29d. Detelsigned (Month, Day, Year) 29c. License number 29b. Signature end title of cartifier

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) 301

420 32. Registrer's Signature

**DHMH 16 Ray 6/95** 



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#10e,19b per FH G763 9/24/98 FW Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death 1001 10301 UN IGE 12 4a. Facility Name (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death LLICOTT CON 6N5 1) URSING HowAn KEHAR (05/172 Hours Min. 8. Data of Birth May 1. If Undar 1 Yaar 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) Anada 5. Social Sacurity Number Days 90 Months 051-18-7658 Usual Basidance of Dacadant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21042 U.S.A. 3626 Comus Lane Cornus Lane 12. Was Dacadant Evar in U,S. Armad Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Baca - American Indian Black, Whita, atc 1 ☐ Yas 2 No If Yes, Giva 1 Navar Married 2 Married 1 Yes 2 No Spacify: White Specify: 3 Widowad 4 □ Divorced 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry **Printing** Elemantary/Secondery (0-12) Collaga (1-4or 5+) Inspector 6 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Sarah Parsons Joseph M. White 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 3626 Gemus Lane Ellicott City, Maryland 21042 Mrs. Evelyn Baker/Daughter 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 09/14/98 Baltimore, Maryland Metro Crematory 22. Nama and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 21. Signature of Funeral Survice Licensea MOO 535 Pnt1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, ock, or heert failure. Approximata Intarval Batween Ongat and Death Immadiata Cause (Finel o months disaasa or condition rasulting in daath) Sequantially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Diseasa or Injury that initiated avents rasulting in daath) Last Due to (or as a consequence of): Dua to (or as a consaquance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Uhknown 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performad? 1 Tyas 2 No 1 ☐ Yas 211NO 26. Placa of Deeth (Check only ona)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. Stata

Director

Funeral

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Completed

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.Funeral

Director

7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examinar must be notified at

end Mental Hygiene.

Department of Health Important: If flam 27

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Pages 1 and 2 should be sent of Health end Mental

with the Maryland

death

filed within 72 hours efter

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

Division of Vital

The law

Physician/Medicai 94 Completed by page 2

signed by Deen 100 certificate Hospital or Attending Physician: 24 hours efter death.
Funeral Director: After this certilities they filled in by the funeral director. Be 2 Certification:

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	1 Yas a No	
27	Manager of Death	

1 Vo Natural 2 ☐ Accidant

5 Pending Invastigation 6 Could not ba datamined 3 Suicida 4 Homlcida

28a. Data of Injury (Month, Day Year)

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28h. Time of

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

Othar: Nursing Homa 5 Rasidance 6 Othar (Specify) 28d. Dascribe how injury occurred

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

29e. Certifiar (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at tha time, dete end place, and due to the cause(s) end mannar as stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and mannar stated.

29b. Signeture and title of certifiar

lecan

Piaca of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

29c. License number

29d. Date signed (Month. Dav. Year) 98

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30. Nama and address of parson who completed causa of death (Itam 23a) (Type, Print) ASNEEM 1220 M

State Registrar

Medical pietely



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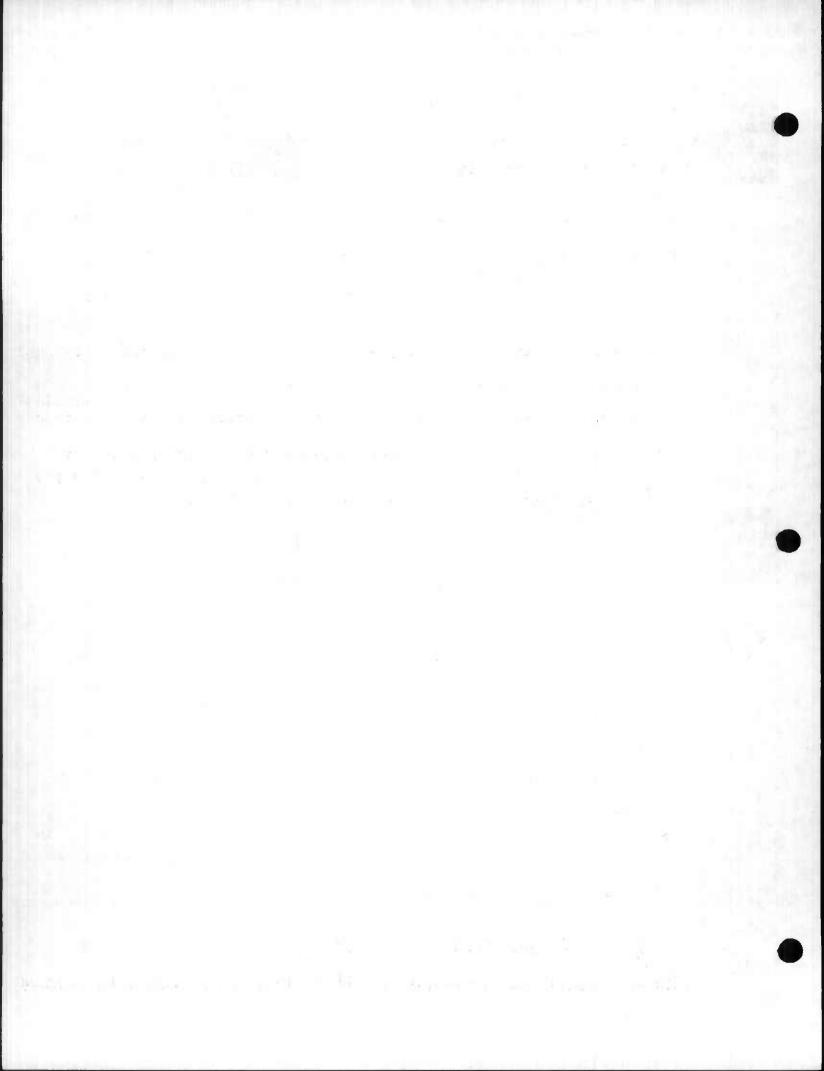
### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Dolores Stewart 1:38 pm September 14, 1998 /Medical 4a. Facility Name (If not institution, giva straat and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Johns Hopkins Boyview Medical center Baltimore If Undar 1 Yaar | If Under 24 Hrs. 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 01-17-29 Birthplaca (State or Foreign Country) **Funeral** Days 10 M 20 F Months Hours 088-22-5768 69 Director MD Usual Rasidance of Decedent the Maryland 10a State 10b. County ns 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits XYas 2□No Director MD NA Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 925 N. Broadway Apt. #402 21205 Funeral death 12. Was Dacedent Ever in U,S Armed Forces? or items Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Ricen, etc.) 14. Race - American Indian, Black, White, atc. 11 Marital Status the Medical Examiner within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Navar Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: p Specify: Black 3 ☐ Widowed 4 ☐ Divorced 'natural', Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Nurse St. Agnes Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Pages 1 and 2 should be nent of Health and Mental is marked 2 Theodore Fowler Georgia Kelson permit. Pages 1 and 2 shou Department of Health and M Important: if Item 27 is marl any injury or other traumati 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 5 Milfords Gardem Court Baltimore, Maryland Denise Stewart McRae 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State Cem.09-18-98 Baltimore, Md. Baltimore 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signatura of Funeral Service Line MA WM.C.March FH 110 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina. Approximate Intarval Between Onsat and Daath Physician /Medical Immediate Cause (Final a. Cordiac arrest disease or condition resulting in death) minutes Examiner Dua to (or as e consequence of): Examiner Renal Failure Acute clan and burial-transit days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events Due to (or as a consequence of): Box 68760, Congestive Heart Failure monThs Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) d. Chronic Obstructive Pulmonary Discase years requires that the death P.O. | Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 X Yes 2 □ No 3 Probably 4 Unknown gastrointestinal bleed Records, by 9 24b. Were eutopsy findings available prior to page 2 should Completed 24a. Was an autopsy performad? hypertension completion of cause of deeth? The jaw certificate chronic renal insufficiency 1 Yes 2 240 1 Yes 2 No of Vital or Attending Physician: director. Be 25. Wes case referred to medical 26. Piece of Death (Check only one) Hospital: 1 Mapatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 20 No this the funeral 27. Manner of Deeth Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After Division 5 Pending Investigation 1 Naturel Injury 1 ☐ Yes 2 ☐ No 24 hours after death 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha ceuse(s) and manner stated. Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. Licansa numbar 29b. Signature and title of cartifiar 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 98036 september 16,1998 Neme and address of person.

Neme and address Medical Doctor 4940 Eastern avenue Baltimore Maryland 21224 31. Date filed (Month, Day, Year) State SEP 1 8 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. 29c State of Maryland / Department of Health and Mental Hygiene
Amend: #23a Part Ib, Part II Per MD Film G763 9-18-98RC Cartificate of Dooth Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dey 3 Month Adolf **Physician** 0150 Salamon 1:23 PM September 1998 /Medical 4b, City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner Baltimore Singi Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) N/A Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 12 M 2□ F Months Yrs 179-05-4706 87 Director 16, 1910 Usual Residence of Decedant the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show rrottled at 1 Yes 2 No Directo MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with other than "natural", or itema 23a or vent, the Medical Examples must be 1500 BEDFORD AVENUE #206 21208 U.S.A. death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 to Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married 1 ☐ Yes XX No Specify: WHITE Baltimore, Maryland 21215-0020 Specify: by Widowed 4 □ Divorced WWIT Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. CHAUFFEUR TRANSPORTATION 11 raumatic event, 18. Mother's Name (First, Middla, Maiden Sumame) 17. Father's Nama (First, Middle, Last) Be Pages 1 and 2 should be fament of Health and Mentel Int: If item 27 is marked of DAVID SALAMON LENA HADL 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BERNARD W. SALAMON (SON) 6734 SURREYWOOD LANE BETHESDA, MD 20b. Place of Disposition (Name of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) important: If it any injury or CHIZUK AMUNO ARLINGTON 9/4/98 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 the disease, or domplications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, eart failura. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediata Cause (Final Renal 1 week disease or condition resulting in death) Examiner Due to (or as a consequence of) Examine TONGUE CANCER physician and the bunal-trensit deeth certificate be executed Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of): as nse 23b. Did tobacco use contribute to the cause of death? ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3⊠ Probably 4 Unknown 1 ☐ Yes 2 ☐ No by sign d be 24b. Ware autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy Completed s certificate has b 1 Yes 2 No 1 Tyes 2 No Division of Vital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27, Mannar of Death 28b. Tima of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 5 Pending Investigation 1 Natural 1 ☐ Yes 2 No death. 2 Accident 4 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 24 hours 29a. Cartiflar 12 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and placa, and dua to the cause(s) and manner as stated Medical

To the Hosp within 24 hos To the Fune completely fi

State Registrar (Check only one)

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29b. Signeture and title of certiling

DeLue 3. Registrer's Signature

MD

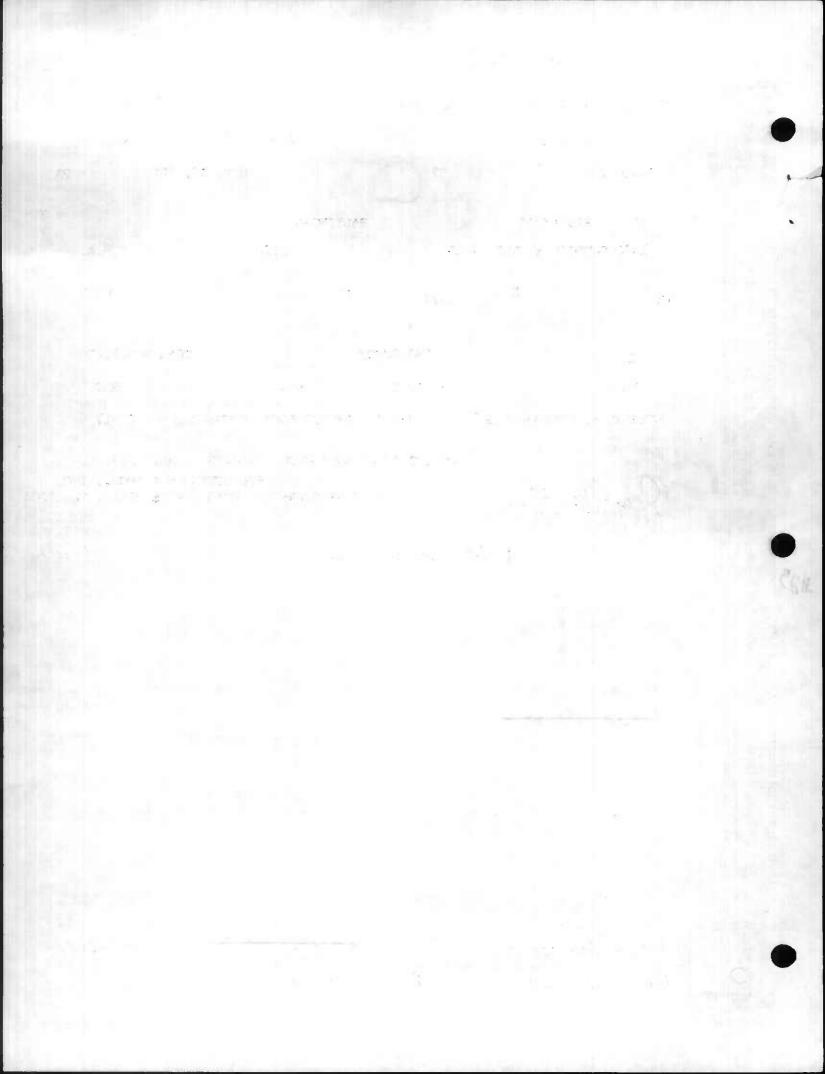
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai

2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number P11228

29d. Date signed (Month, Dey, Year)

September 3,1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #1 Per MD Film G763 9-25-98RC Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** SMITH ROYAL QUINTIN SMITH , JR. ROYAL 5:50 P.M. 091 121 1998 /Medical 4a. Fecility Name (If not Institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ellicott Baltimore Driveway 5. Social Security Numbar If Under 1 Year If Undar 24 Hrs. 6 Sex 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foraign Country) **Funeral** 1XM 20 F Days 36 Yrs. 215-70-5216 Director Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Baltimore 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò 2908 Ellicott Herrs 23a riveway 21216 .S.A Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No It Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 5 1□ Yes 2 No Black py 3 ☐ Widowed 4 ☐ Divorced Specify: "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation
(Give kind of work done during most of working life., PO NOT use retired) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within Department of Haalth end Mental Hygiena. Important: If Item 27 Is marked other than any injury or other traumatic event. It has the Mental Inc. Elementery/Secondary (0-12) College (1-4or 5+) 24 grade JURK 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Royal Smith aru 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Driveway Dalmore,
Dete 20c. Location - City or Town, Steta He 20e. Method of Disposition 20b. Place of Disposition (Name of cometery cremetory or other place) 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stata enetury 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22, Nama and Address of Fecilif Wakash 300 Grenue 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tellure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting In deeth) stage Examiner Physician/Medical Examiner Julia dependent Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequance of): Due to (or as a consequence of): Part II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. P.0. 23b. Did tobacco use contribute to the causa of death? 1 Tes 2 No 3 Probably 4 Unknown signed b Myperterior Records, à 24b. Were autopsy findings eveilebla prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificete Division of Vital Be 25. Wes cese referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 2 1 Yes 2XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Deeth 28e. Dete of Injury (Month, Dev Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 5 Pending Investigation 1 Neturel 1 Yes 2 No 2 Accident 3 Suicide

Hospital or Attending Physician: 24 hours after death. Director: To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b

4 \ Homicide

6 Could not be determined

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Location (Street end Number or Rural Routa Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2 Medical Examinar: On the basis of examination end/or Investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) end mennar stated.

Baltimore

29b. Signature end title of certifier

247804

29d. Date signed (Month, Dey, Yeer) 09/14/1998.

21229

nome 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 530 N. Hilton JW. MROWIEC

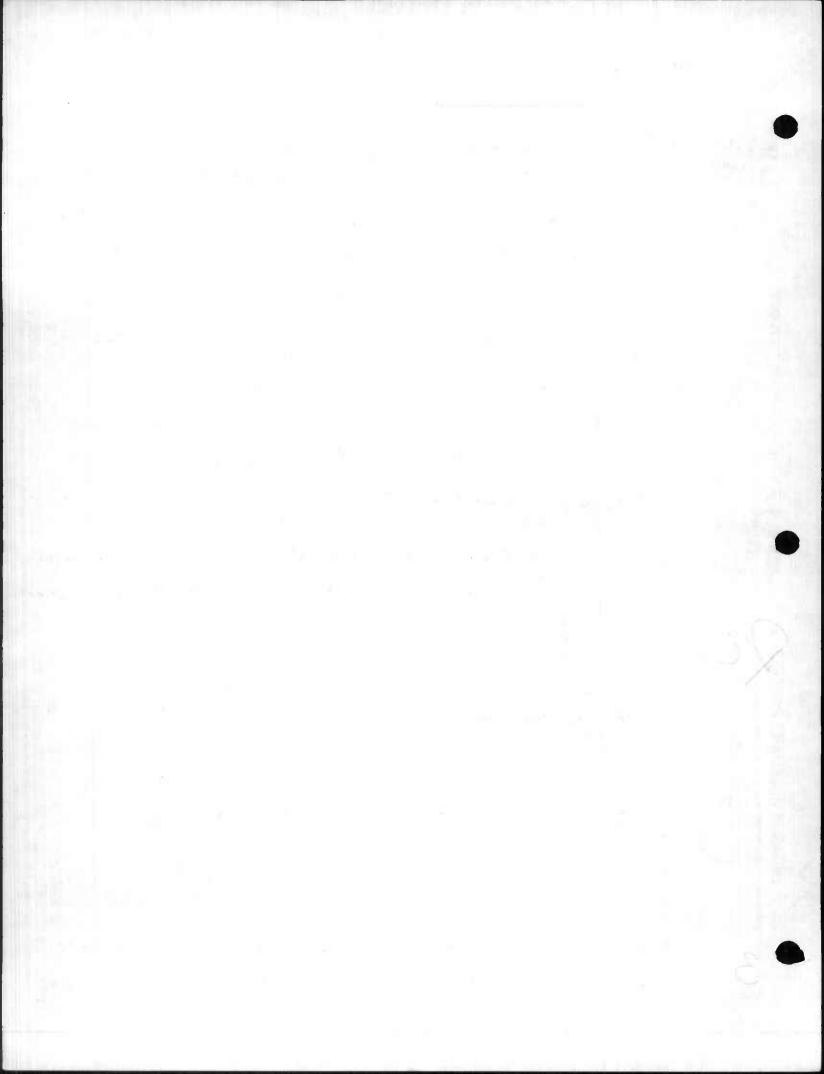
31. Dete filed (Month, Day, Year) SEP 1 8 1998

32. Registrer's Signeture

29c. License number

edicai

29a. Certifier



	State of Maryl		rtificate				leg. No. 9 8	2	8674
1. Decedent's Neme (First, Middle,	Last)		- IV.			2. Date of Dee		Yeer	3. Time of Death
dical Jessie C	atherine S	Seward				SEPTEM		1998	5.57 A
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	NDEL HOS	yrs. lest birthdey)	If Under	1 Year	GLEN If Under 24 Hrs	DURNI B Date of Birth		J N E	RUNDE lace (State or Foreign
216-20-7118	1□M 2ÅF	72 Yrs.	Months	Deys	Hours Min	8. Date of Birth (Month, Dey July 29	, 1926	Count	aryland
Usuel Residence of Decedent  10a. State 10b. County	10c	. City, Town or Lo	ocation					10	Od. Inside City Limits
	Arundel	**	adena						1 ☐ Yes 2 🌣 No
10e. Street end Number			10f. Zip				10g. Citizen of V	Whet Coun	try?
8393 Lockwood	Road			211				SA	
11. Meritei Status 1 ☐ Never Merried 2 ☒ Merrie	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☐ No	in U,S. 13.	Was Deced	ent of H ify Cuba	ispanic Origin? (8 an, Mexicen, Puer	Specify Yes or No- to Ricen, etc.)	14. Rac Bled	e - America ck, White, e	
1 ☐ Never Merried 2 ☑ Merrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	No K	Specify:		Specify	/ Whi	te
15. Decedent's (Specify only highest		16e. Dece	dent's Usue	Occup	ation during most of wo	rkina	16b. Kind of Br	usiness/Ind	lustry
Elementary/Secondary (0-12)	College (1-4or 5+)				d)		E 4		
9 17. Father's Neme (First, Middle, Li	etl	Со	unselo	or	18 Mother's Ne	me (First, Middle,		catio	n
	ars					ine Mill		,	
19a. Informent's Name/Reletionshi		19b. Meili	ng Address	(Street		ural Route Numbe		Stete, Zip	Code)
Robert W. Seward	, JrHusband	839	3 Lock	(WOO	d Road,	Pasadena	, MD 21	122	
20a. Method of Disposition 1 X Buriel 2 ☐ Cremetion 3		b. Plece of Disponentery, cre-	osition (Nem metory or of	e of her plea		Dete	20c. Location -	City or To	wn, Stete
4 □ Donation 5 □ Other (Spe	cify) (	Cedar Hi				Sept.19			Maryland
21. Signeture of Funeral Service Li	ensee					Stallings			
Muschelf	Stallers	1.10				d, Pasad		2112	
23e. Pert . Enter the disease, or c shock, or heart failure. List of	in plicetions that caused in a large street in a	Do not en	ter the mode	e of dylin	ig, such es cerdie	c or respiretory en	rest,		Approximete Intervel Between Onset end Deeth
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thet initieted events resulting in deeth) Lest	Due t	to (or es e consec	quence of):					1	
	d								
Part II. Other significent condition	contributing to death but not	t resulting In the u	inderlying ce	use giv	en in Pert I.	23b. Dld t	obacco use co	ntribute to	the cause of death
						101	res 212 No	3 Prot	bably 4 Unknow
				=1		24a. Wes	an autoney	24b. We	ere eutopsy findings
						perfo	med?	ava	allable prior to impletion of ceuse death?
						100	es 2 1 No		Yes 212 No
25. Wes cese referred to medical					26. Piece of De	eth (Check only o			2 100 Z WO NO
exeminer? 1 ☐ Yes 2 ☑ No	Hospitel: 1 Inpatient	2 ER/Outpetie	nt 3 DO	A Oth	OF!	Home 5□ Resid		er (Specif)	y)
27. Menner of Deeth 1 ☑Naturei 5 ☐ Pending	28e, Dete of Injury (Month, Dey Yea	28b. Time o Injury		Bc. Injur Wor		28d. Describe h	ow injury occur	red	
2 Accident investiga		At home of the second	M factors		Yes 2□No	ORI Location (f	treat and Non	ner or Prim	l Route Number,
4 Homicide determin	28e. Place of Injury - A building, etc. (Sp	nt nome, tarm, st pecify)	reet, ractory	, οπισθ		City or Tow	n, State)	er or mura	THOUSE SYNTHOUS,
29a. Certifier 1 € Certifying	Physician: To the best of my	knowledge, deet	h occurred e	et the tin	ne, dete end plea	e, end due to the	ceuse(s) end m	enner es st	tated.
(Check only 2 Medical Ex	aminer: On the besis of examend menner stated.	minetion end/or In	vestigation,	in my o	pinion, deeth occ	urred et the time,	date end place,	end due to	the ceuse(s)
29b. Signature and title of contiller	44=				e number		29d. Date signe		
140	_ MEDICAL	DOCTOR		000	0522	77	SEPTEM	BER	1717 1998
30. Neme end eddress of person w	A	(Item 23e) (Type,	Print)	_	A 0.1.12	HACA.	7 A 1	11	14.1
FRANCIS KWA	ISHIE ATTIO	ABE 1	10111	1	TKUNDE	L HOSPI	ITTL 1	MATLY	LKNU.

32. Registrer's Signature

9. Sparks

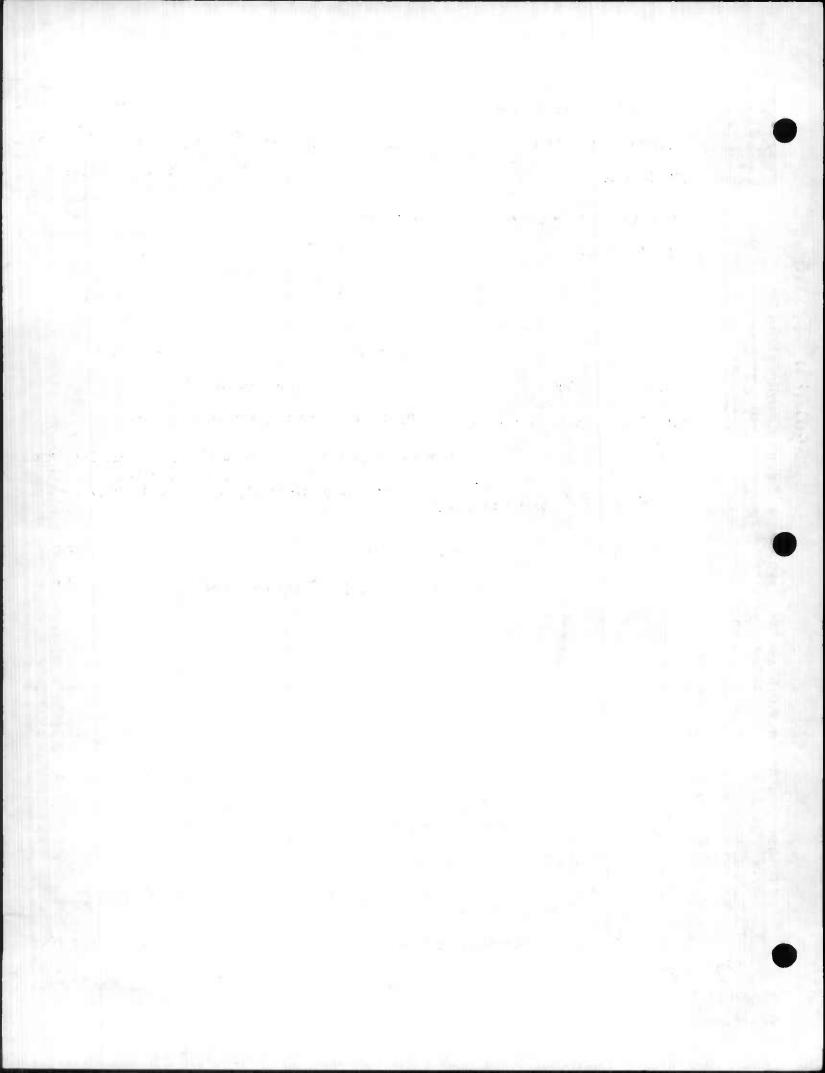
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DHMH 16 Rev 6/95

State

Registrar

SEP 1 8 1998



ician	#8 per FH G763 9/18/9			ertificate of	Dodin		Reg. No	20	0/0
ician	1. Decedent's Name (First, Middle,					2. Date of Dea Month	th Day	Year	3. Time of Death
dical	JOSEPH ARTH	IUR SANDBEK		A STATE		Septemb		1998	1:45 pm
niner	4a Facility Name (If not institution, g	rive street and number)			4b. City, Town, or	Location of Death			- 1
	FALLSTON GENERAL	HOSPITAL		3.00	FALLSTO	NC	HARF	ORD	
	502-09-3386	. Sex 7. Age (In 82	yrs. last birthda Yrs.	y) If Under 1 Yea Months Days			, Year) 1916	9. Birthplac Country Minne	
	Usual Residence of Decedent  10s. State 10b. County	100	c. City, Town or	Location				104	Inside City Limits
tor	Maryland Harfo		o. Only, Town or	Fallst	on			100.	1 ☐ Yes 🎗 🖾 No
Director	10s. Street and Number			10f. Zip Code			10g. Citizen of V	What Country	7
	1610 Watervale F	Rd.			21047		USA		
by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1  Yes X2(XNo If Yes, Give Year or Dates:	in U,S. 13	B. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 (X) No.	ban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	Blac	a - American ck, White, etc	
P	15. Decedent's	Education	16a. Dec	cedent's Usual Occi	upation	orkina	16b. Kind of Bu	usiness/Indus	try
pje	(Specify only highest ( Elementary/Secondary (0-12)	College (1-4or 5+)	life	. DO NOT use retir	ed)	nowny			
Completed	12 yrs.	2 yrs.	Me	chanical			Aireco		
Be	17. Father's Name (First, Middle, La	st)				me (First, Middle,		19)	
To	John Sandbek				Alice	Olive Lea	it		
	19a. Informant's Name/Relationship	(Type, Print)	19b. Me	iling Address (Stree	et and Number or F	iural Route Numbe	r, City or Town,	Stete, Zip Co	ode)
	Mrs. Vera L. Sa	ndbek	16	10 Waterv	ale Rd. I	Fallston,	Md. 21	.047	
	20a. Method of Disposition		0b. Place of Dis	position (Name of rematory or other pl	ace)	Date	20c. Location -	City or Town	, State
	N Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control of Control			of Faith		9-15-98	Baltim	ore. M	ld.
	21. Signature of Funeral Service Lic			22. Name and Add	ress of Facility			.525, 1	
	1 97 4	11		E. F. Las 11750 Bel					
	23a. Part 1. Enter the disease or co shock, or heart failure. List on Immediate Cause (Finat disease or condition resulting in death)	a	,	^	pirato		ilur		terval Between nset and Death
9			2.16		1.50	p. t. 0	fachs or	42 4	(0000)
edicai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Chronic Due	to (or as a cons	equence of):	inters	litical	Jebro	sis y	lears
Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Chronic Due		equence of):	inters	litical	fibro	sis y	lears
hysician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Chronic Due	to (or as a cons	equence of):	inters				lars we cause of death?
Physician/Medical	resulting in death) Last	b. Chronic Due	to (or as a cons	equence of):	inters		Jobacco use con	ntribute to th	
by Physician/Medical	resulting in death) Last	b. Chronic Due	to (or as a cons	equence of):	inters	1 🗆 '		3 Probet	autopsy tindings ble prior to letion of cause
by Physician/Medical	resulting in death) Last	b. Chronic Due	to (or as a cons	equence of):	inters	1 🗆 '	ree 2□ No an autopsy med?	3 Probate  24b. Were availa comp of der	autopsy tindings ble prior to letion of cause
Completed by Physician/Medical	Part II. Other significant conditions  25. Was case referred to medical	b. Chronic Due	to (or as a cons	equence of):		1 U	an autopsymed?	3 Probate  24b. Were availa comp of der	autopsy tindings ble prior to letion of cause htt?
o Be Completed by Physician/Medical	Part II. Other significant conditions	b. Chronic Due  c. Due  d. contributing to death but no	to (or as a cons	equence of): equence of): underlying cause g	26. Place of De	24a. Was perfo	en autopsymed?  (es 25 No	24b. Were availa comp of det	autopsy tindings ble prior to letion of cause htt?
To Be Completed by Physician/Medical	Part II. Other significant conditions  25. Was case referred to medical axaminer?	b. Chronic Due c. Due d. Contributing to death but no dea	to (or as a cons  t resulting in the	equence of):  equence of):  underlying cause g  ent 3 DOA Of 28c. Inj	26. Place of Do	24a. Was performent (Check only of Home 5   Resident	en autopsymed?  (es 25 No	3 Probat  24b. Were availa comp of det  1 V	autopsy tindings ble prior to letion of cause htt?
cation: To Be Completed by Physician/Medical	Part II. Other significant conditions  25. Was case referred to medical axaminer?  1 Yes 2 No  27. Manger of Death 1 Natural 5 Pending	b. Chronic Due  c. Due  d. Contributing to death but no d	to (or as a cons  t resulting in the	equence of):  equence of):  underlying cause g  ient 3 DOA Col of 28c. Inj W	26. Place of De hither: 4 □ Nursing ury at ork? □ Yes 2 □ No	24a. Was performed to the control of	en autopsymed?  res 25 No ne)  lence 6 Oth now injury occur  Street and Numb	3 Probat  24b. Were availa comp of deat  1 Year (Specify)	autopsy tindings ble prior to letion of cause th?
Certification: To Be Completed by Physician/Medical	25. Was case referred to medical axaminer?  1   Yes   2   No  27. Manger of Death 1   Natural   5   Pending investigat 3   Suicide   6   Could not determined  29a. Certifier   Check only   2   Medical Exc	b. Chronic Due  c. Due  d. Contributing to death but no d	to (or as a conset to conset to the second t	equence of):  equence of):  equence of):  underlying cause g  ient 3 DOA 0 28c. Ini M 1[ street, factory, office ath occurred at the	26. Place of Do	24a. Was performent of the control o	an autopsymed?  (es 25 No ne)  Jence 6 Oth now injury occur  Street and Number, State)	24b. Were availa comp of det 1  Y	autopsy findings ble prior to letion of cause ath?  less 2 No  loute Number, autopsy findings ble prior to letion of cause ath?
cation: To Be Completed by Physician/Medical	Part II. Other significant conditions  25. Was case referred to medical axaminer?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could not determine  29a. Certifier 1 Certifying I	b. Chronic Due  c. Due  d  contributing to death but no  cont	to (or as a conset to conset to the second t	equence of):  eq	26. Place of Do	24a. Was performed to the control of	an autopsymed?  (es 25 No ne)  Jence 6 Oth now injury occur  Street and Number, State)	24b. Were availe comp of det 1 1 Y	autopsy tindings ble prior to letion of cause th?  es 2 No  route Number, e cause(s)

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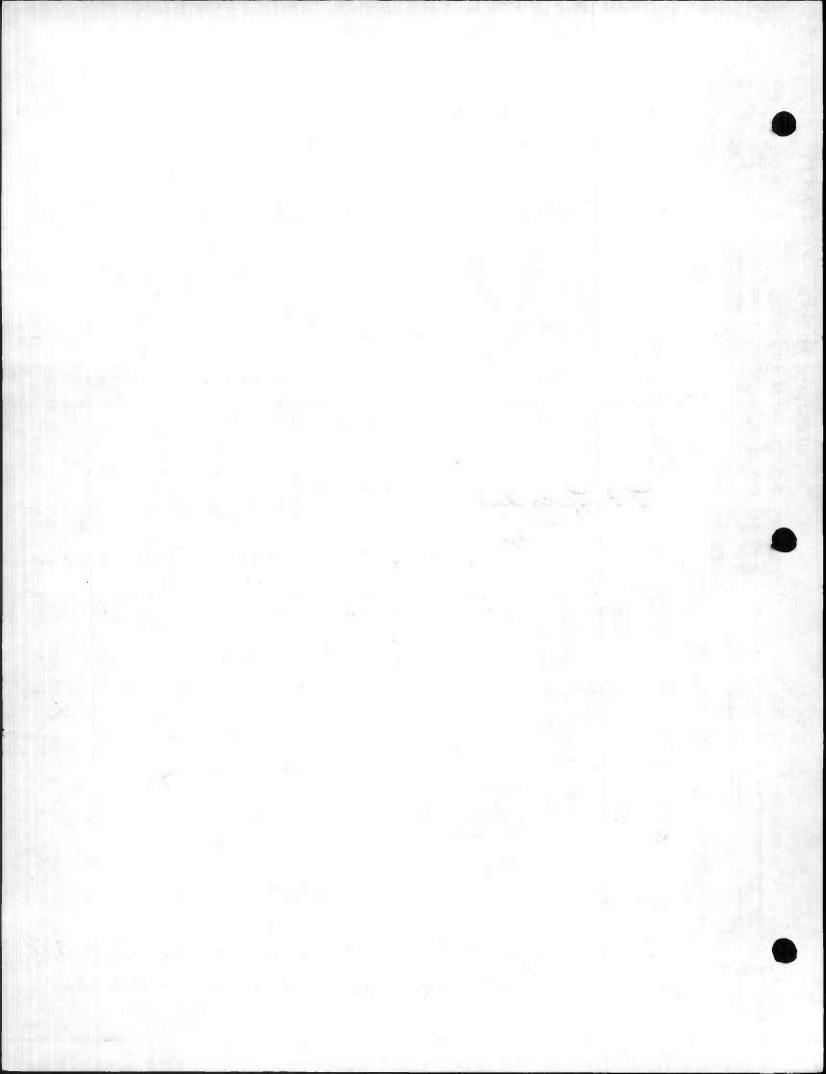
State of Maryland / Department of Health and Mental Hygiene

**DHMH 16 Rev 6/95** 

State Registrar M.D. 1800 Harford Road, Fallston, MD 21047
32. Apostrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#4c per Phy G763 9/18/98 EW 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month VOLK WILLIAM 6:08 AM Depti 1998 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth SAMARITAN BALTIMORE (200D HOSA If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) 15€M 2□F 216206871 Poland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore City 1X Yes 2□No Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6015 Carter Avenue 21214 USA 12. Was Decedent Ever In U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Electronics Engineer Electronics 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) John Emanuel Volk Lucv N. Schvornuk 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Dorothy M. Volk (Wife) 6015 Carter Avenue, Baltimore, MD 21214 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 20c. Location - City or Town, Stete 4 ☐ Donetion 5 ☐ Other (Specify) Holy Trinity Rus. Ordx. Cem9/8/98 Elkridge, Maryland 21. Signet of Funeral Service Livensee 22. Neme end Address of Fecility Altenburg Funeral Home Martin D. Lawson 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest,

Approximate

Approximate Immediate Ceuse (Final disease or condition resulting in deeth) SEPSIS PERITONITIS Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest PERFORATED LEUKEMIA Phocy 23h. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28d. Describe how injury occurred

**Physician** /Medicai Examiner

Examiner

**Physician** 

/Medical

**Examiner** 

10e. State

Direct

à

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer death a Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner marks once.

Baltimore, Maryland 21215-0020

with the Maryland

Box 58760

Division of Vital Records, P.O.

this certificate hes

I or Attending Physician: efter death. Director: After this certific funeral To the Hospital of within 24 hours of To the Funeral D completely

Registrar

Physician/Medicai Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. þ Completed 25. Wes cese referred to medicel examiner? 1 ☐ Yes 2 ☐ No 10 27. Manner of Deeth Certification: 28c. Injury et Work? 5 Pending Investigation Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 🗺 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. Medical 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end manner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

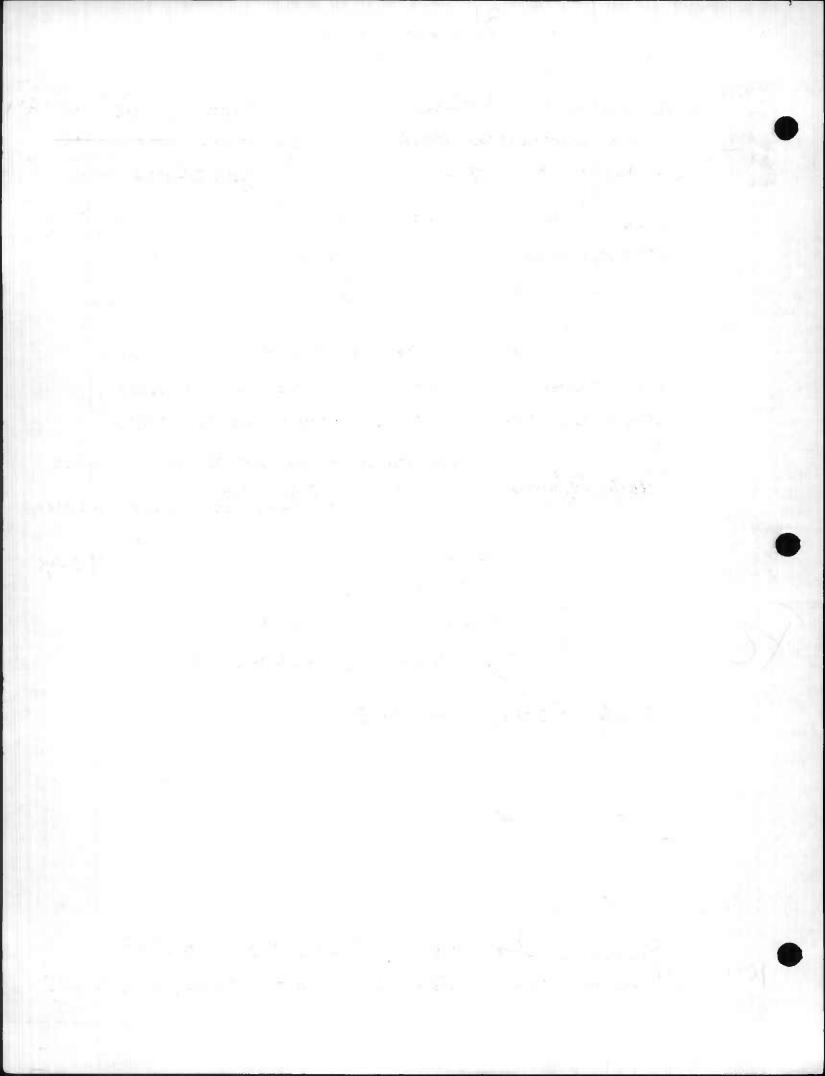
5 31. Date filed (Month, Dey, Yeer)

SEP 1 8 1998

30. Many and eddress of person who completed ceuse of death (Item 23e) (Type, Print)

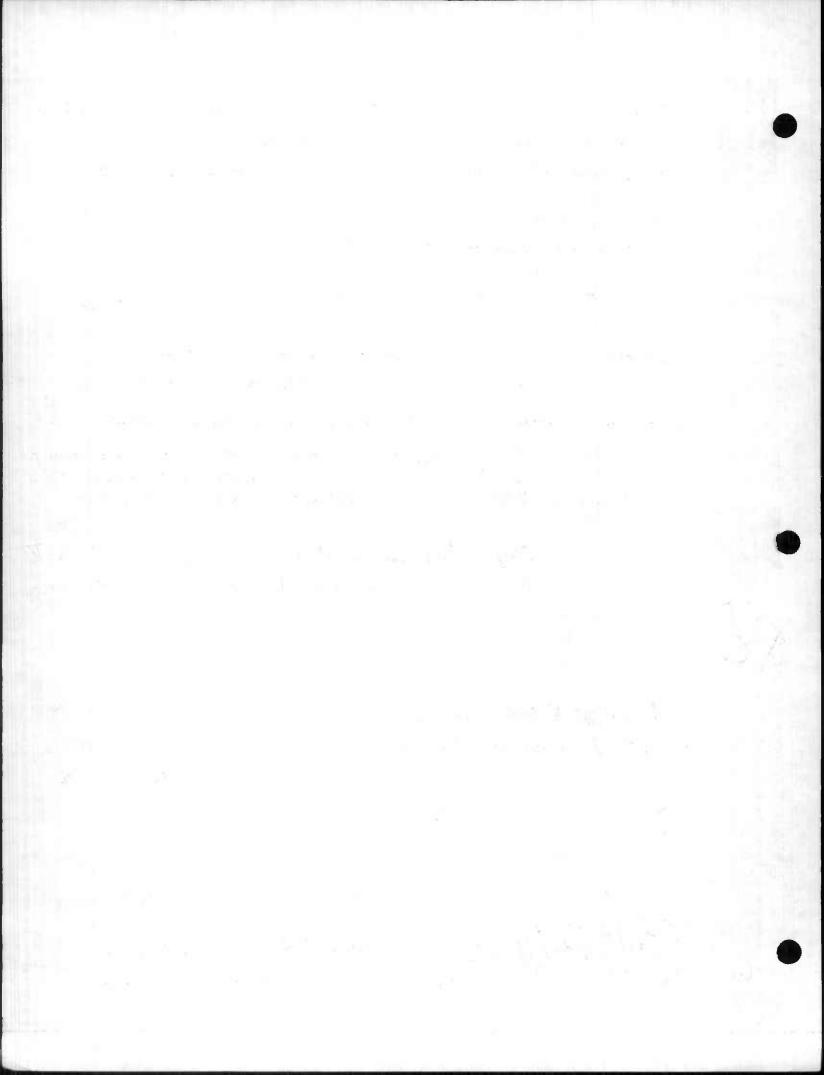
5601 32. Registrar's Signature

Loch Raver BLVD BALTIMORE



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Decedent's Neme (First, M	tiddle laet		Certi	ficate of	Death	2. Dete of De	Reg. No.	8	3. Time of Deeth	
Physic		920 - 100	nouve, casty		1777	rmm		Month	Dey	Yeer		
/Medi Examir		WILLIAM 4e. Fecility Neme (If not institute)	ution, give street and num	nber)	WH.	ITE	4b. City, Town, or L		BER 14,1		3:15 p	
EXAMILE	nei	THE JOHNS HO				1	BALTIMORE		NA	0, 000,,,		
Funeral	г	5. Social Security Number		7. Age (In yrs. les		If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, De		9. Birthol	ace (Stete or Foreic	
Director		246-44-2096 Usuel Residence of Decedent	1 M 2 □ F	66	Yrs.	Months Deys	Hours Min.	06-02	2-32	N C	ace (Stete or Foreig ry)	
show	_	10e. State 10b. Cou			Town or Loca					10	d. Inside City Limit	
the Maryle 28a-f shor	ecto	MD  10e. Street end Number	NA	Ват	timore						X1X Yes 2 N	
th with	Funeral Director	2109 Guilfo	ord Avenue	Apt."	ot."A" 21218				USA	/het Count	ry7	
or Ite	by	11. Marital Status  1 Never Married 2 Nover 3 Widowed 4 Divor	Armed For Married 1 ☐ Yes if Yes Give	<b>AFX</b> No	If Y	s Decedent of I es, specify Cub Yes 2 No	Hispenic Orlgin? (Spen, Mexicen, Puerto Specify:	pecify Yes or No Ricen, etc.)	14. Race Blec Specify	- America k, White, a	etc.	
72 nai	Completed	15. Dece (Specify only hig Elementary/Secondary (0-1	dent's Education ghest grade completed)  2) College (1-		16e. Deceder (Give kir. life. DO	nt's Usual Occup nd of work done NOT use retire	pation during most of work id)	king	16b. Kind of Bu			
D 75 -	ပိ	4th Grade 17. Fether's Name (First, Midd		Cement Finisher								
ntal H	Se se	Charlie	White				18. Mother's Nam Evelin		, Maiden Sumem Huggi	,		
d 2 should be filed within the end Mental Hygiene. 7 Is merked other than traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event.	70	19e. Informent's Neme/Releti			19h Melling	Address (Street	t end Number or Ru				Code) 2121	
s 1 end 2 should f Health end Men tem 27 Is marke other traumatic		Marjorie	White				rd Aveni				,	
permit. Pages 1 er Depertment of Hea mportant: If item 2 nny Injury or other MCs.		20a. Method of Disposition	WIIICC			on (Neme of ony or other ple		Date	20c. Location -			
Page: ent ol nt: If i		1 Burial 2 Crematic	on 3 ☐ Removel from S	Kin		m.Pk.		9-19-9	8 Rand	alls	stown, N	
permit. Pages 1 end 2 Depertment of Health e Important: If Item 27 Is any Injury or other tra once.		21. Signature of Funeral Serv		2	22. N	lame and Addre				_	nd 21202	
		23a. Pert1. Enter the disease shock, or heert failure.	or complications that ca	used the death.						7	Approximete Intervel Between	
Examiner of a property of a pr	Medical Examiner	disease or condition resulting in death)  Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury thet Initiated events resulting In death) Lest	b. ATho	Due to (or e	es e conseque es e conseque	nce of):	n dise	ne		6	30 MIZTO	
attend for us	clan											
by the	Physician/N	Pert II. Other eignificent cond				erlying ceuse gi	ven in Pert I.			tribute to	the cause of death	
v raquiras been sign should be	Completed by	perphenal	VASCUM	Dide.	ALR			24a. Wes	en autopsy ormed?	com	re autopsy findings ilable prior to apletion of ceuse eeth?	
iclan: The law certificate has rector, page 2	Com							10	Yes 200 No	1 🗆	Yes 20 No	
lane ortific ctor,	Be (	25. Wes cese referred to med	tical				26. Plece of Deel	h (Check only o	one)			
Physician: this certific ral director,	P	1 No 2 No	Hospitel: 1 🗆 in	patient 20 EF	VOutpetlent	3□ DOA Oth	ner: 4 Nursing Ho	ome 5 Resi	dence 6 □Othe	er (Specify)	)	
ng P	on:	27. Manner of Death 1 Denatural 5 ☐ Per	28e. Dete of (Month)	Injury 21 Day Year)	8b. Time of injury	28c. Inju		28d. Describe	Describe how Injury occurred			
tendi seath tor: A the f	cat	2 Accident Inve	estigation				Yes 2 □ No					
al or Attending s efter death. I Director: After d in by the fune	Certification:		emined 289. Place	of Injury - At home g, etc. (Specify)	e, farm, street	, fectory, office		28f. Location (	Street end Numbe wn, State)	er or Rurei	Route Number,	
To the Hospital or Attending Physician: within 24 hours efter death. To the Funersi Director: After this certifial completely filled in by the funeral director.	edlcai (	29a. Certifier 1 Certific (Check only one) 1 Medic	fying Physicien: To the bacal Examiner: On the basend manner	sis of exemination	edge, death oon n end/or inves	ccurred et the tir tigation, in my c	me, date and place, ppinion, deeth occur	end due to the red at the time,	cause(s) and mar dete end plece, e	nner es sta and due to	ated. the ceuse(s)	
Vithin Fo the	Me	29b Signature and the of cent	9010			29c. Licens	se number		29d. Dete signed	(Month, E	lay, Yeer)	
- > - 0		V CH DA	Eley &	N		039	288		9/14	198		
(-		30. Name and address of pers	on who compand ceuse	of death (Item 2	3e) (Type, Pri	nt)					Brither	
0		621 T S	charl J-	CM -	1830	5. /	MUNUMMI	-5-	SIT	4/6	CM	
Sta Registr		31. Date filed (Month, Day, Ye	9ar) 32. Re	gistrer's Signetur		1	1 (-10(11)	9.	0-11	118	/- 0	



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year JAMES SEPTEMBER 14 1998 WILSON 11.40A Am 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death RANDALLSTOWN BALTIMOREI 140SPITAL CENTER NORTHWEST If Under 24 Hrs. 8. Date of Birth Hours Min. SEP 8 1913 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex Days Months 1**€**M 2□ F SOUTH CAROLINA 85 214-03-7930 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a State 10b County 1 XX es 2 □ No MARYLAND N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1310 IDYLWOOD ROAD 21208 14. Race - Americen Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 V Yes 2 □ No If Yes, Give Year or Dates: 43/46 1 Never Married 200 Married Specify: BLACK 1 ☐ Yes 2 ☒ X o Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) SHIPPING LONGSHOREMAN 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ELLICK WILSON BEULAH WILSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 1310 Idylwood Road, Baltimore, Maryland 21208 Thelma Wilson/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XX Buriel 2 Cremetion 3 Removal from State CROWNSVILLE VETERANS 9-18-98 CROWNSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY F/H, P.A 21. Signature of Funeral Service License 1206 W. NORTH AVENUE 3a. Part. Enter the disease, or complicate is that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only or course on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or es a consequence of) AINOMUZNA. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown RENAL INSUPPICIENCY CHRONIC 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 → Compatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28d. Describe how injury occurred

**Physician** /Medical Examiner

Physiclan/Medical Examiner

Completed

Be

10

Certification:

edical

1 Netural 2 Accident

3 ☐ Suicide

29b. Signature and

31. Date filed (Month, Day, Year)

SEP 1 8 1998

29a. Certifier

4 Homicide

Important: If the any injury or oth pages

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or terms 23e or 28a-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

filed within Hygiene.

phode

h and Mental is marked of 8

1 and 2 s if Health at them 27 is

Pages 1

Director

Funeral

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Completed

signed by the a certificate has

Physician: After this funeral

Records, P.O. Box 68760 Division of Vital spital or Attending Prous after death. within 24 hours a

To the Funeral C

completely filled Hospital

10

State Registrar

5 Pending investigation 6 Could not be

an

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 7 HYSI (1 A 29c. License number D42723

29d. Date signed (Month, Day, Year) SEPTEMBER 14

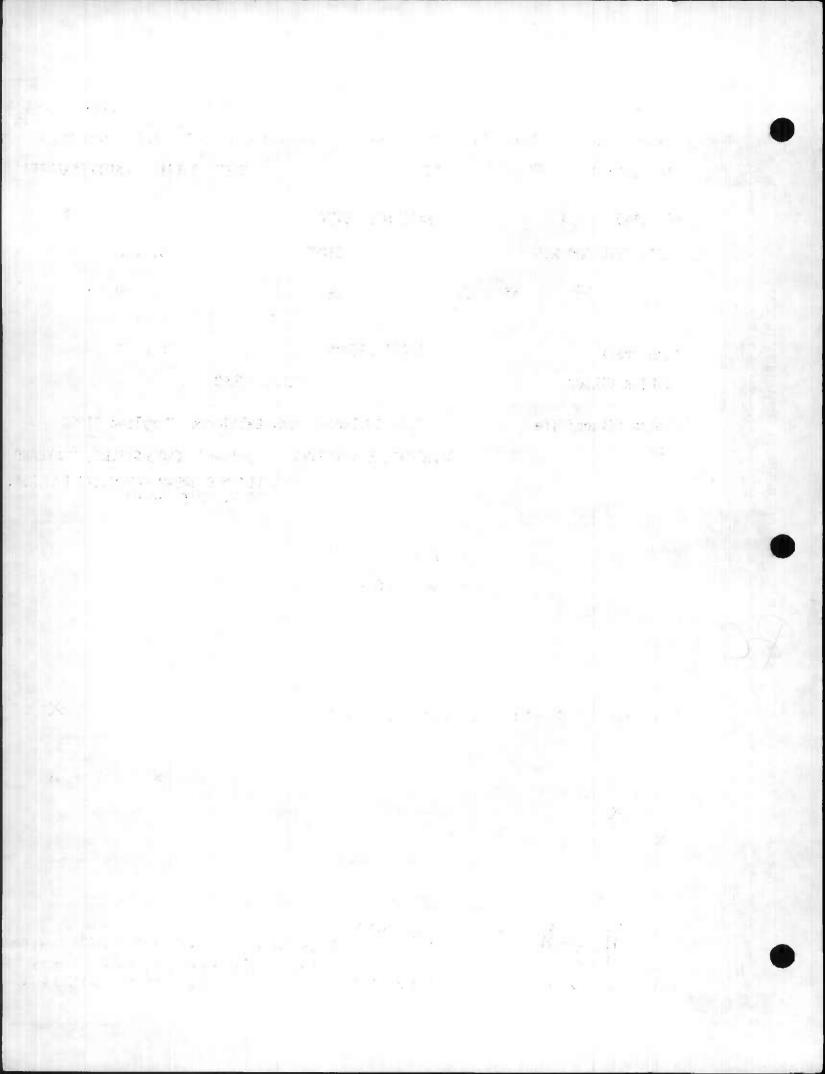
3745 STREBM FOX-FORP

11:40 Am RP

person who completed cause of death (Item 23a) (Type, Print) 30. Name and ad HARISH AVYEIZAHALLI

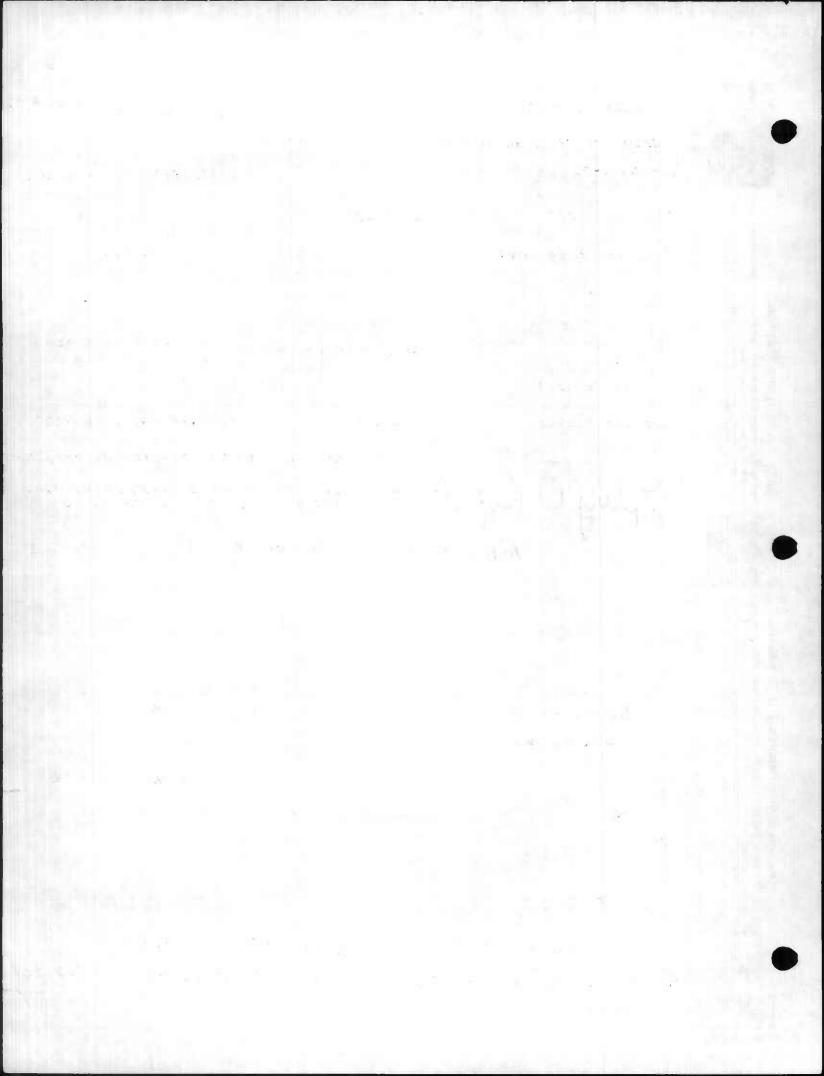
m 32. Registrar's Signature

HOUSE



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name (First, Middla, L	est)		Certifica	e or	Death	2. Dete of De	Reg. No.		3. Time of Death	
Physician			LLACE					Month	Day	Year	2.05 A	
/Medical		4a Facility Neme (If not institution, g	4b. City, Town, or L	ocation of Deeth		78 of Deeth	3					
Examiner	r	CATON MANOR	Baltin			N/A						
Carrent I				n OM E (In yrs. last birti	hday) If Unde	r 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birthol	ace (State or Fore	
Funeral Director		249-05-7678			Yrs. Months	Days	Hours Min.	(Month, Da 05/15/	y, Yaar)	Coun	carolina	
*	-	Usual Residence of Decedent  10a. Stete 10b. County		10c. City, Town	or Location					10	0d. Inside City Lim	
23a or 28a-f show uni be notified at		MD N/Z		Bai	ltimor	е					1 <b>∕</b> Yes 2□	
r 28	Director	10e. Street and Number			10f. Zi	Code			10g. Citizen of W	het Coun	try?	
238.0		3715 Colborne	Road				21229		U .	S.A.		
of, or items	by Fur	11. Marital Status  1 ☐ Never Married 2√ Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent E Armed Forces? 1 Yes 2 14 If Yes, Give Year or Dates:				lispenic Origin? (Sp an, Mexicen, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race Blac Specify	- America k, White, d		
naturel',	Completed	15. Decedent's I	Education	lucation 16a. Decedent's Usual Occ				ina	16b. Kind of Bu	siness/Ind	lustry	
than or	ed -	Elementary/Secondary (0-12)	College (1-4or 5	College (1 Acc 5 c) life. DO NOT			d of work dona during most of working NOT usa ratired)			Bro	thers	
or than	00	6th		S	oap Bl	ende	er					
I to E	Be	17. Father's Name (First, Middla, Las								a)		
nd Mental marked o umatic sv	0	James Wallad				E11a	McFal	1.1				
and Is ma		19e. Informant's Name/Relationship					end Number or Rui					
Health Sm 27 ther tr		Lecolia Mille	er				iage Cou	irt, Ba				
If Item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3	TRemoval from State	camatan	Disposition (Na y, cramatory or	othar pla	ce)	Date	20c. Locetion -	City or To	wn, Stete	
int:	4	4 Donation 5 Other (Spec		Mt.	Zion C	eme	tery 9/1	9/98	Baltim	ore,	Maryl	
hysician /Medical xaminer		23a. Party Enter the disease, or conshock, br heart failum. List only Immediate Cause (Final disease or condition resultion in death)		the deeth. Do note.	4600 not enter the mo	LIB de of dyir	DYETT OF ERTY HEST	OF respiratory a	AVE., BA			
22232		resulting in death)		Due to (or as e c	consequence of)	:				1		
clan and burisi-transi	Examiner	Sequentially list conditions, if any, leading to immediate	b	Due to (or as a c	consequence of)	:				1		
	ig Ca	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	C	Due to (or as a co	onsequence of)					1		
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ettending for use e	clar							1				
d by the ettending eteched for use e	hysi	Pert II. Other significent conditions  Dem En		it not resulting in	the underlying	ceuse giv	ven in Part I.		Yes 20 No		the cause of de pably 4 🗆 Unki	
be det	by											
te hes been signed by the ettending page 2 should be deteched for use.	Completed	ANAG	mIA					24e. Was perfo	en autopsy omied?	ava	ere eutopsy finding allable prior to impletion of ceuse death?	
ate hes page 2	omo							10	Yes 25(No		Yes 20 No	
		25. Was case referred to medical					26. Place of Dea					
	0	examiner?	Hospital:	nt 2 ER/Out	tpatient 3 D	OA Oth		-	dence 6 □Othe	er (Specifi	()	
erthis neral d		27. Manner of Deeth	28a. Date of Injur	y 28b. T		28c. Inju			how injury occurr			
After funer	atio	1 Natural 5 Pending 2 Accident investigati	11 1511 1511									
te de	TITIC	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Streat and Number or Rural Route Number, City or Town, State)			
s efter deeth. If Director: After and in by the fu	29a. Certifier (Check only (Ch											
24 hours effer deeth.  • Funeral Director: Affert letely filled in by the funeral certification:	colcal Ce	29a. Certifier Check only one) Certifying F	miner: On the basis of and manner sla		d/or Investigation	n, in my c	opinion, death occui	red at the time,	date and place, a	and due to	the ceuse(s)	
in the function of the functin of the function of the function of the function of the function	edical	(Check only 2 Medical Ext	miner: On the basis of			c. Licens	se number		29d. Dete signed	d (Month,	the ceuse(s)  Day, Year)	
in 24 hours he Funer pletely fill edical	Medical	(Check only one) 2 Medical Ext	Inliner: On the basis of and manner sta	D	29	C. Licens	se number		29d. Dete signed	(Month,	o the ceuse(s)  Day, Year)	

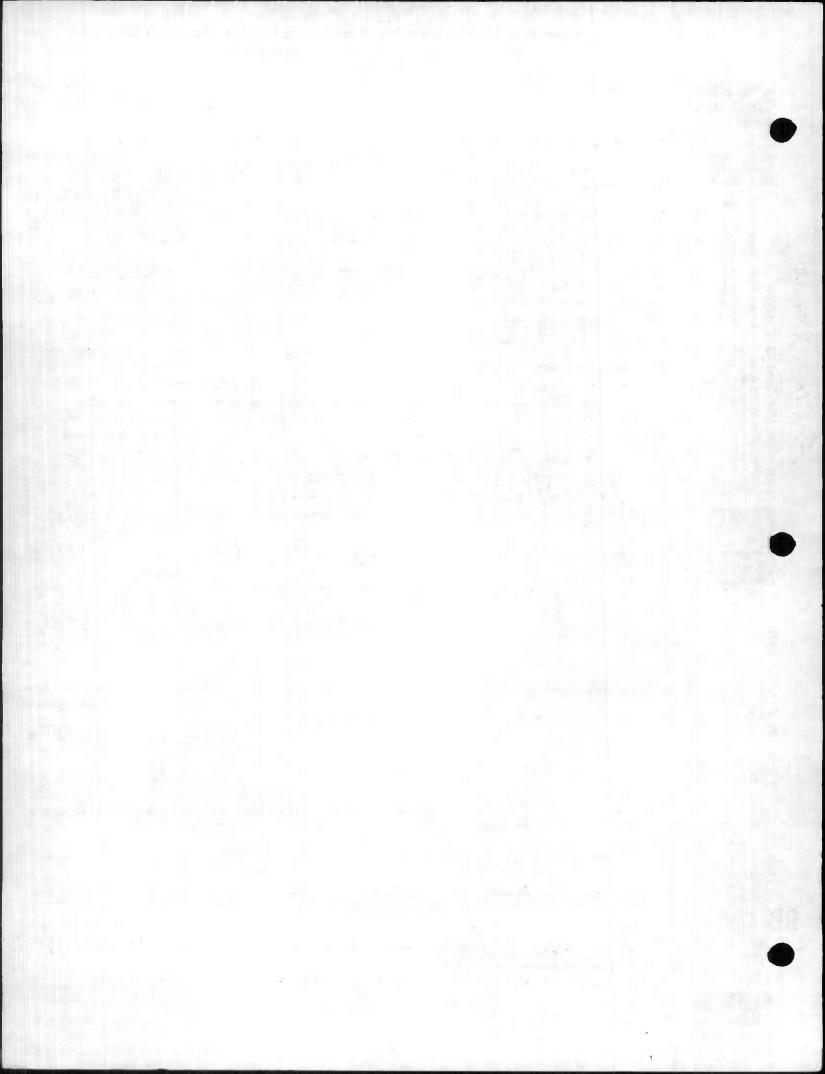


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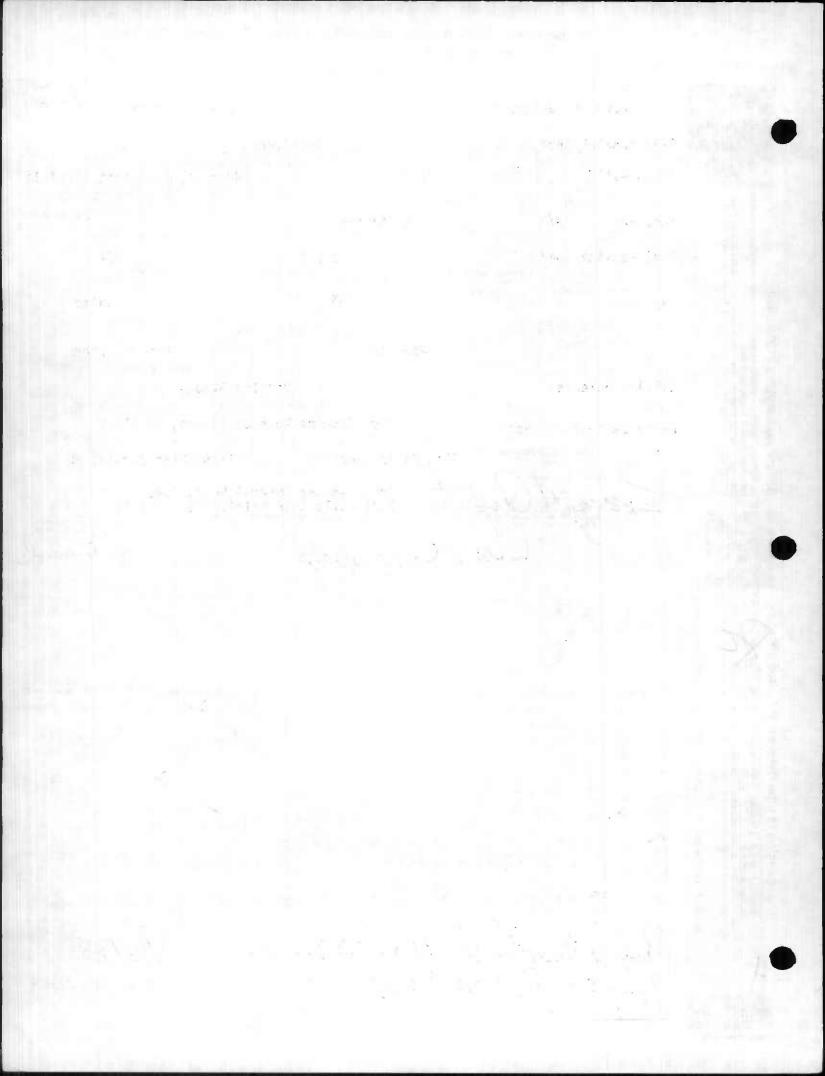
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 17, Month SEPT. **Physician** 1998 2:40 AM Frank Osler Watson /Medical 4b. City. Town, or Location of Death 4e Facility Name (If not institution, give street end number) 4c. County of Death Examiner Baltimore Glen Meadows Health Center Glen Arm If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeer Birthplaca (Stete or Foreign Country) **Funeral** Days Months Yrs. APR 6, 1911 Canada Director 219-03-0269 Usuel Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Glen Arm Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21057 USA 11630 Glen Arm Rd., Unit #39 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 ☐ Yes 2 No
If Yes, Give
Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Weather Instruments Senior Designer 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Pages 1 end 2 should be nent of Health end Mental Carrie Osler Edgar Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 11630 Glen Arm Rd. Unit #39 Glen Arm, MD 21057 Ruth C. Watson / Wife 20b. Place of Disposition (Neme of cametery, cremetory or other pleca) 20a. Method of Disposition Dete 20c. Location - City or Town, State Department of Important: If it sny injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory, Inc. 9/17/98 Baltimore. 21. Signature of Funeral Service Lipense 22. Name and Address of Facility Cremation Society of Maryland, Dawn F. McDonal Mulo C 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediete Ceuse (Final respiratory disease or condition resulting in death) Examiner Examiner te pulmmyry
Due to (or as a consequence of): that the death certificate be executed physician and the buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Coronary Physician/Medical signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dld tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 donknown cerebral à 24b. Were eutopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 (Other (Specify) Hospite 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide ghe 6 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner es steted.
2 Madical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number ptember 17, 1998 no 30. Name and address of person who completed cause of death ofem 23a) (Type, Print) Anthony Riley, M.D. 6701 N. Charles St. Towson, MD 21204 31. Date filed (Month, Dey, Year) 32 Registrer's Signature State 1 8 1998 MAN Registrar

**DHMH 16 Rev 6/95** 

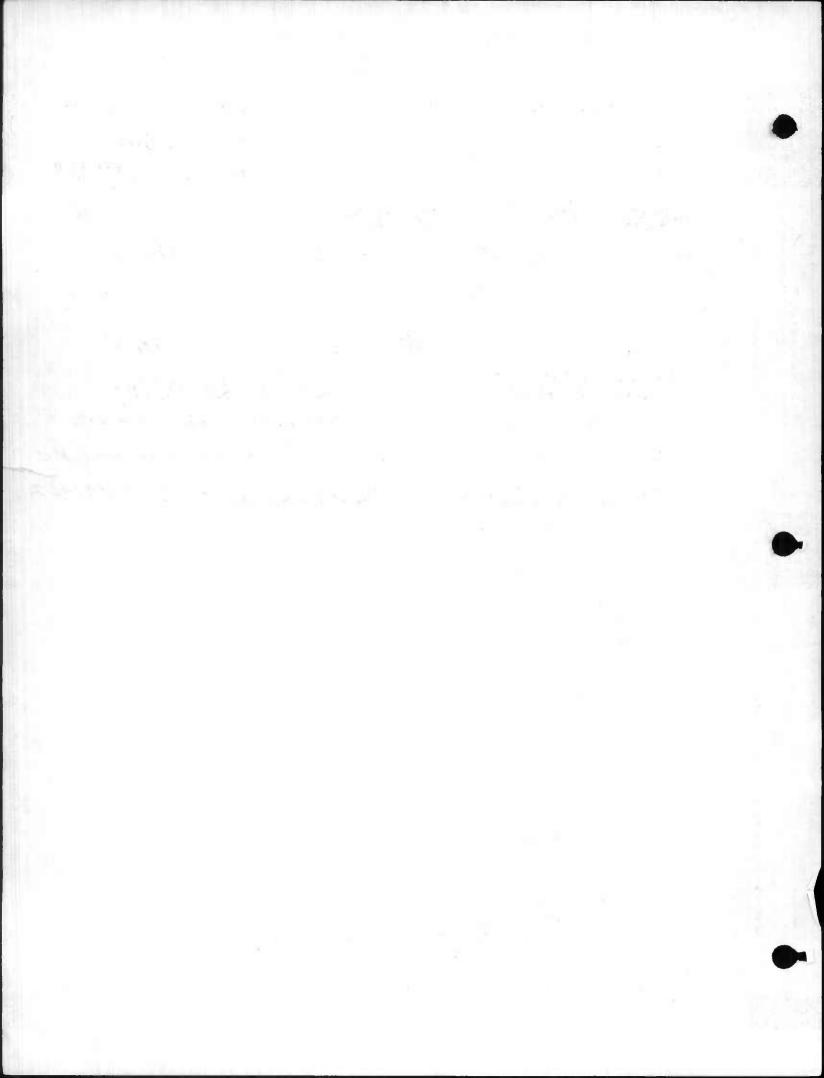


State of Maryland / Department of Health and Mental Hygiene Amend: #31 Per DVR Film G763 9-18-98RC Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 30 AM **Physician** Audrey L. Whittaker Sept. 14, 1998
eation of Death 4c. County of Death /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street end number) Examiner Baltimore
| If Under 24 Hrs.
| Hours | Min. 2942 Keswick Road Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthdev) 8. Date of Birth (Month, Dev. Year) **Funeral** Days 1□ M XX F Months Yrs. 73 Director 232-38-1117 June 14. 1925 West Virginia Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10e State 10b. County 10c. City, Town or Location "natural", or items 23s or 28s-f show XI Yes 2 □ No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2942 Keswick Road 21211 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer loppartment of Health and Mental Hyglene. Important: If Item 27 is merked other than "natural", or Iten eny Injury or other treumatic event, the Medical Example 2028. 1 Never Married 2 Married 1 Yes 2√No Specify: P 3XXWidowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Manager Grocery Store 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) William DeWeese Bartley Skeens 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. tnforment's Name/Relationship (Type, Print) 2906 Keswick Road Baltimore, MD 21211 Larry DeWeese Son 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 ☑ Buriat 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 9/17/98 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 21. Signature of Funeral Servica Licanue 22. Name and Address of Facility 3631 Falls Road Bal: 3631 Fall Burgee-Henss Funeral Home, P.A. 3631 Falls Road Baltimmore, MD 21211 23a. Part 1. Enter the dis-shock, or heart failu Approximate tnterval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) UNG ACINO Examiner Due to (or as a consequence of): Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequença of) Physician/Medical Division of Vital Records, P.O. Box 687 Due to (or as a consequence of): The law requires that the death 23b. Dtd tobacco use contributa to the cause of death? by the Part It, Other significant conditions contributing to death but not resulting in the underlying cause given In Part It. 2 12 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24e. Was an autopsy performed? Completed peen s completion of cause of death? hes page 30/40 1 ☐ Yes 2 No certificate or Attending Physician: 25. Was case referred to medical exeminer? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: After 1 Naturat 5 Pending Investigation 1 Yes 2 No Director: A 2 Accident 3 Suicide 6 ☐ Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 24 hours after Funeral Dire Hospital 29a. Certifier Eartifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner as stated. edicai (Check only one) 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. To the F the 29b. Signature and title of our 29c. License number 29d. Date signed (Month, Day, Year) 0 leted cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp GBMC Touson, MD 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP Registra



State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** FRUSHIA 1944 P.M. WILKINS September 15 1998 /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner HUR CH HOSPITAL BALT, MORE 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth Months Days Hours Min. (Month, Day, 10/23) 5. Social Security Number (State of Foreign 1□M 2XF 22762415 Director 23 Usual Residence of Decedent the Maryland 10b. Count State 10d. inaide City Limits tem 27 is marked other than "natural", or items 23s or 28s-f sho other traumatic event, the Madical Examines must be nothing at 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code permit. Pages 1 and 2 should be filled within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examination and any once. 21213 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White Jeto 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yes 22 No à 3 Widowed 4 □ Divorcad Completed 16s. Decedent's Usual Occupation
(Give kind of work done during most of working
| No. DOWNOT use apticabl) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 24 17. Father's Neme (First, Midd an 19a. informant's Neme/Relationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Towns 1316 n. Potomas It Balto 1 hompson 20b. Place of Disposition (Name of cemetery, cremetory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) 10N em. 21. Signature of Funeral Servica Licansee 22. Name and Address of Fecility of a Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory arrest, or haart failure. List only one causa on aach line. Approximata tntervei Between Onset end Death **Physician** /Medical tmmedlete Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Records, P.O. Box 68760 Physician/Medical ğ Due to (or es e consequenca of): Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b þ 24b. Were autopsy findings evalleble prior to completion of cause of death? 24a. Wes en autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medicat Be 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ inpatient 2 € ER/Outpatient 3 ☐ DOA を 28a. Date of injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Anne 1 Naturai 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicida 6 Could not be 28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Cartifiar 🖄 Cartifying Physician: To the best of my knowledge, death occurrad at the time, date and placa, and due to the cause(s) and manner as stated. F 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date end place, and due to the causa(s) and manner stated, To the Hor Within 24 h To the Fur 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Neme end address of person who completed cause of death (Hern 23a) (Type, Print) BALTIMORE BROAD WAY AHUJA N. SUN, L 160 31. Date filed (Month, Day, Year) 32. Registrar'a Signature State 1 8 1998 SEP Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death Month 1140 AM September 1998 15 Donald Wesley Jones 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) of Baltima re Sinai Hospital Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Yaar 5. Social Security Number 6. Sex Birthplaca (Stete or Foreign Country) 7. Age (In yrs. last birthday) Days 1□XM 2□ F Months Yrs. 215-30-2686 62 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Y Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 U.S.A. 5615 Fern Park Avenue 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Naver Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Assemblyman Auto 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fathar's Nama (First, Middla, Last) Mildred Ellen Rolex Wesley Donald Jones 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Diane Jones/ Wife 5615 Fern Park Ave. Baltimore, Maryland 21207 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Spacify) 09/23/98Baltimore, Maryland Woodlawn Cemetery 22. Name and Address of Facility The Derrick C. Jones Funeral Hm. 21. Signature of Funeral Servica Licensee 4611 Park Heights Avenue, Baltimore, Maryland 21215 at enter the moda of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications the vaused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastatic Abdaminal Cancer, Unknown primary disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Sunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1□ Yes RENO Yas 2 □ No 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1□ Yes 25 No 1 Dopatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 2 Accidant 5 Pending 1 Tyes 2 No investigation 6 Could not be determined 3 Suicida 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Examiner end -transit the death certificate be executed physician e Physician/Medical 80 150 ō signed by the a þ Completed il director, page 2 s Be 2 this Certification: After

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f ahow

than "natural", or items 23s or the Medical Examiner must be

r is marked other

Item 2

Department of important: If it any injury or o

**Physician** /Medical

Examiner

Peges 1 and 2 should be 1 nent of Health end Mentel I int: If Item 27 Is marked of

altimore,

Directo

Funeral

by

Completed

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with

72 hours after death

filed within

Records, P.O. Box 68760, Division of Vital or Attending Physician: 

completely To the Vithin 2

State Registrar 29b. Signature and title of cartifier

4 ☐ Homicide

(Check only one)

29a. Certifier

edical

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and manner stated. 29c. License number

🕰 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

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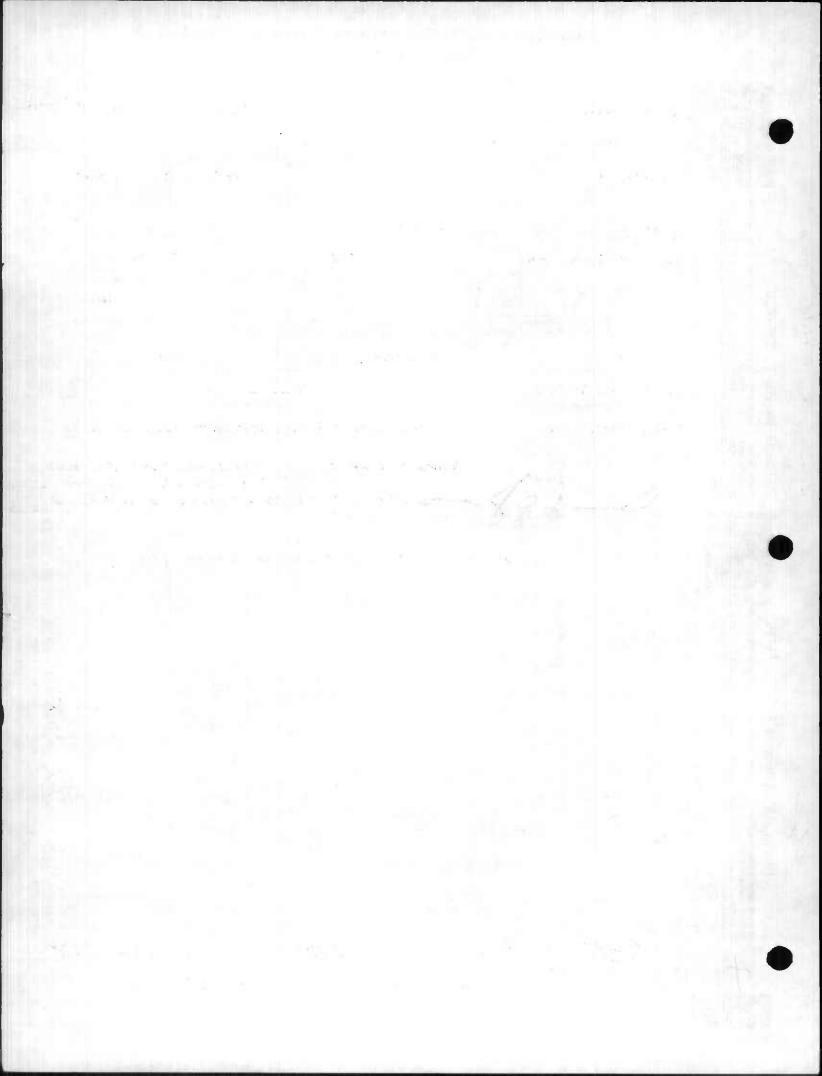
September 15, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kathyn a. Barna MD -d,

Hospital of Baltimore

31. Date fited (Month, Dey, Yeer) SEP 1 9 1998 32. Registrar's Signature Sneva



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month GEORGE PURNELL 8:30A SEPTEMBER 12, 1998 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, AUG 29, MEDILAL CENTER BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1Q-M 2□ F 35 Yrs. Unknown Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No N/A BALTO 10e. Sfreef and Number 10f. Zip Code 10g. Citizen of What Country? 2332 GUILFORD AVE 21218 U.S.A. 12. Wes Decedenf Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. Never Married 2 ☐ Married 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: BLACK 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A UENEMPLOYED 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GEORGE HOLMAN LENORAL PURNELL 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) LENORA PURNELL/mother 2332 GUILFORD AVE BALTO, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other pleca) VOSHELL MEM GARDENS 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 9-17-98 BALTO, MD 4 ☐ Donation → ☐ Other (Specify) 22. Name and Address of Facility BETTS FUNERAL HOME 21. Signature of Edneral Service Licensee 1129 N. CAROLINE ST BALTO MD 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 6months Due to (or as a consequence of):

**Physician** /Medical Examiner

permit. Pege Department of Important: If any Injury or

**Physician** 

/Medical

Examiner

10a. State

8th

**Funeral** 

Director

"natural", or items 23s or 28s-f show edical Examiner must be notified at

Peges 1 and 2 should be filed within 72 hours after onent of Health end Mental Hyglene.
Int: If Item 27 is marked other than "natural", or itee iry or other traumatic event, or Medical Examines

Baltimore, Maryland 21215-0020

Records, P.O. Box The law requires that the deam

Division of Vital

by Funeral Director

Completed

Be

with the Maryland

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last Physician/Medicai

Due to (or as a consequence of): Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 26. Place of Death (Check only one) STELLA MARIS AT MERCY

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Menner of Death

5 Pending investigation

6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

Deno ma

28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 TYes 2 □ No 28d. Describe how Injury occurred

Other: 4 Nursing Home 5 Residence 6 Stother (Specify) HOSAICE

29e. Certifier (Check only one)

1 Natural

2 Accident

3 Suicide

4 - Homicide

Completed by

Be

Certification: To

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) end manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signeture and fitle of certifier

FERRALDO

29c. License number 040480 29d. Date signed (Month, Day, Year)

To the Hospital within 24 hours a To the Funeral C

certificate

the

filled in by

al or Attending Physician: T s after death. Il Director: After this certificat

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

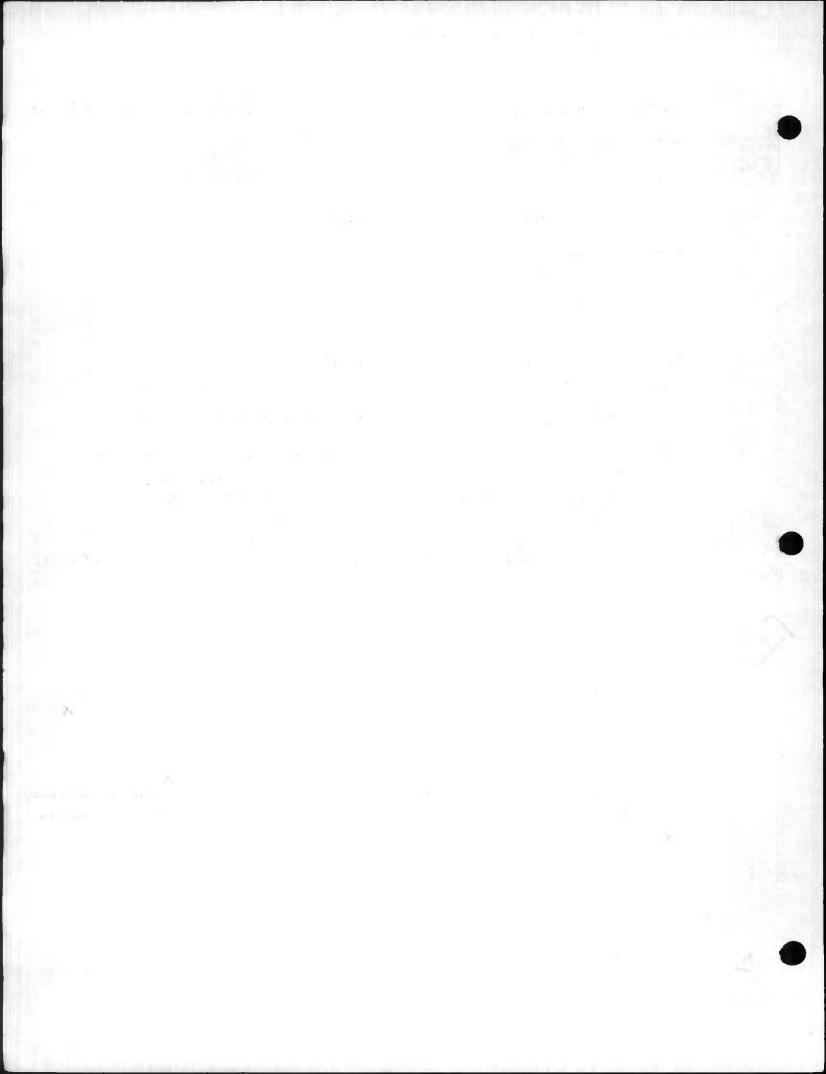
7672

28f. Location (Street and Number or Rural Route Number, City or Town, State)

31. Date filed (Month, Day, Year) State

FERRO 32. Registrar's Signature

Registrar



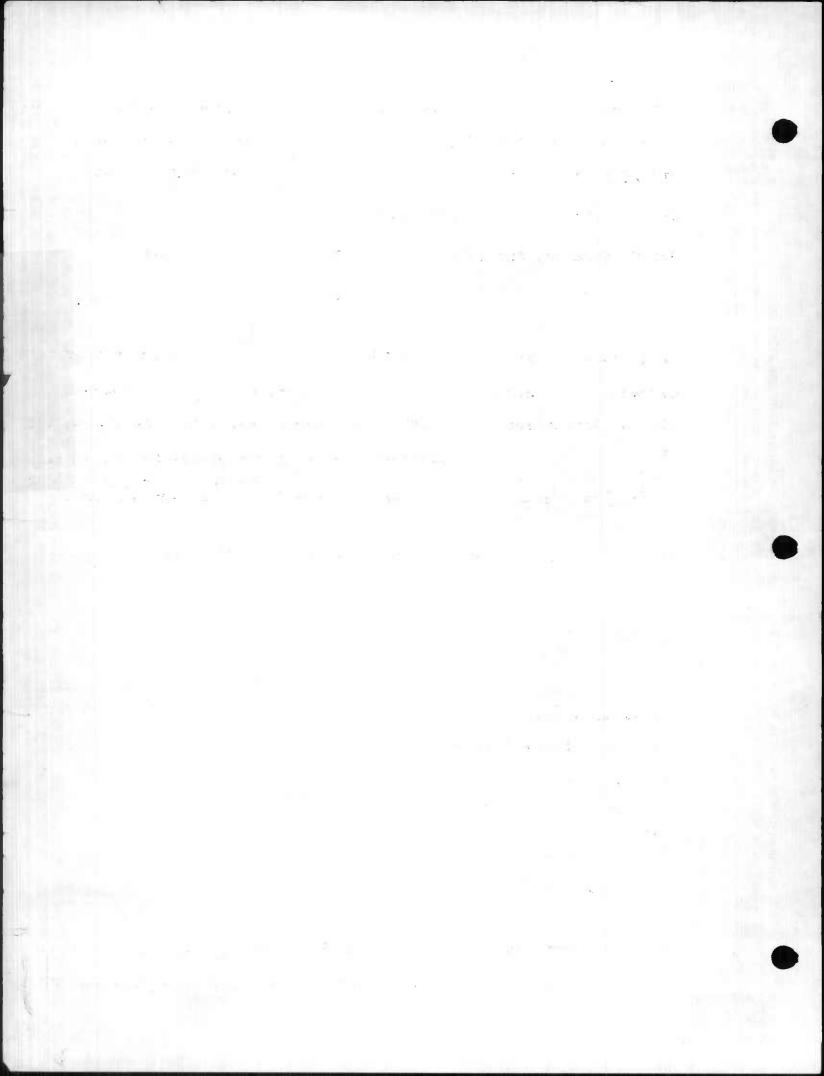
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Dey Yeer **Physician** Bertha Brown September 15, 1998 6:59 AM /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore Johns Hopkins Mospital Baltimore City If Under 24 Hrs. Months Devs 5. Sociel Security Number 6 Sex 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Hours Min. Deys 1□ M 2 F 65 Director 10-12-32 MD 217-24-1210 Usuel Residence of Decedent the Marylend 10c. City. Town or Location 10d. Inaide City Limits 10a Stete 10b County 7 is marked other than "naturel", or items 23s or 28s-f show traumetic event, the Medical Examiner must be notified at MD 1 Yes 2 □ No NA Baltimore Director 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 21205 925 N. Broadway Apt. #403 USA Funeral deeth permit. Peges 1 and 2 should be filed within 72 hours effer deet Department of Health and Mental Hygiena. Important: If New 27 is marked other than "natural". And any Injury or other traumatic event. 14. Raca - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes Completed 18e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Daycare Provider Daycare 12th Grade 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Nathaniel Branch Bertha Woodson 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1409 Limit Avenue Baltimore, Maryland 21239 Richardson Alicia 20b. Plece of Disposition (Neme of cemetery, cremetory or other placa) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete Garrison Forest VA Cem. 09-22-98 Owings Mills, 22. Name end Address of Fecility 21. Si tue of Funerel Servica Licansee Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediete Ceuse (Finai Chronic obstructive pulmanary disease disease or condition resulting in death) years Examiner Due to (or es a consequence of): Examiner physician and s the buriel-tran Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): P.O. Box 68760, Physician/Medical Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. the hed 1 Yes 2 No 3 Probably 4 Unknown 2 acute renal failure signed t Division of Vital Records, à 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? congestive heart failure peeu 1 ☐ Yes 2 ☐ No hypertension

25. Was case referred to medical examiner?

1 yes 2 No 1□ Yes 2□No certificate Hospital or Attending Physician: funaral director, Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 0 this 28c. Injury et Work? Certification: 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Aftar Injun 1 Naturel 5 Pending after death. Director: Aft 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be determined To the Hospital or Atte-within 24 hours after der To the Funeral Directo completaly filled in by th 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homleide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es stated.

2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end pleca, end due to the cause(s) end manner stated. edical 29a. Certifier (Check only one) 29d. Date aigned (Month, Dey, Yeer) 29b. Signature end title of certifier 29c. License number - MD RES - 000 September, 15, 1998 Chris Parsons MD. 1837 Monument Street Svite 910 Baltimore, Maryland 21205
31. Dete filed (Month, Day, Yeer) 32. Registrar's Signature 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) State SEP 2 1 1998 oaks

Registrar



	1. Decedent's Name	e (First, Middle, L	ast)					Death	2. Date of		٧.		3. Time of Death				
ician	Ashl			ı, Jr.					Month	De			11:02 A				
dical niner	4a Fecility Name (I.							4b. City, Town,				777	11.00111				
IIIIIEI	1711	CHILTON S	STREET					BALTI	SEPT. 12, 1998 or Location of Death MORE NA  MORE  Hrs. 8. Date of Birth (Month, Day, Year) 04-06-39  10g. Citizen of What C USA (Specify Yes or No- uerto Rican, etc.)  16b. Kind of Busines Black H. Service Neme (First, Middle, Maiden Surrame) i W. Williams r Rural Route Number, City or Town, State, treet Baltimore, Date 09-19-98 Baltime Baltimore, Mary H 1101 E. North diac or respiretory errest,  SCULAR OCS LOCATION  23b. Did tobacco use contribut 1 Yes 2 No 3	A							
al	5. Sociel Security N		Sex	7. Age (In yrs	. last birthda	ay) If Und	der 1 Year		rs. 8. Date of	Birth	,	9. Birthp	place (State or Foreign				
or	216-34-		1√2 M 2□ F	59	Yrs	. NOTE	15 Days	riours ly									
	Usuel Residence of 10a. State	Decedent 10b. County		10c. C	ity, Town or	Location				10d. Inside City Limi							
ō	MD	N.F	A		altin					x t□ Yes							
Funeral Director	10e. Street and Nur	mber					Zip Code			10a. Ci	itizen of Wi	hat Cour	ntry?				
Ö			Street	Street Apt.#1 212													
Jera	11. Marital Status	11111011	12. Was Dec	-					(Specify Yes or		14. Raca						
F	<b>X</b> Never Marri	ied 2 Married	1 ☐ Yes	2 3 No					erto Hican, etc.)								
1 by	3 Widowed	4 Divorced	If Yes, Gi Year or D	ates:		ILI Tes	2 ₩ No	Specify:			Specify:	Bla	ck				
Completed	(Spec	15. Decadent's E			/G	cedent's U	work done	during most of	vorking	16b. F	Kind of Bus	iness/In	dustry				
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ပိ	12th Gr 17. Father's Name		NA_		Sec	curit											
Be vert	Ashley		Brown,	Sr.				Naom									
To	19a. informant's Na			021	19b. Ma	ailing Addr	ess (Street						Zip Code) 21213				
	Adele	Hurst			263	33 E.	. 01:	iver St	reet B	alti	more, Maryland						
DUCE.	20a. Method of Disp				Placa of Dis	sposition (/	Vame of	ice)	Date	Date 20c. Location - City or Town, State							
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n al er	No	ne disease, or con rt failure. List oni	mplications that	Leros	H So not	WM. Conter the m	and Address C. Mannode of dyi	ess of Facility  Arch FI	Baltim I 1101	E. N	Mar North	yla n Av	and 21202 venue  Approximate Interval Between				
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O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

13, 1998

SEPT.

State Registrar

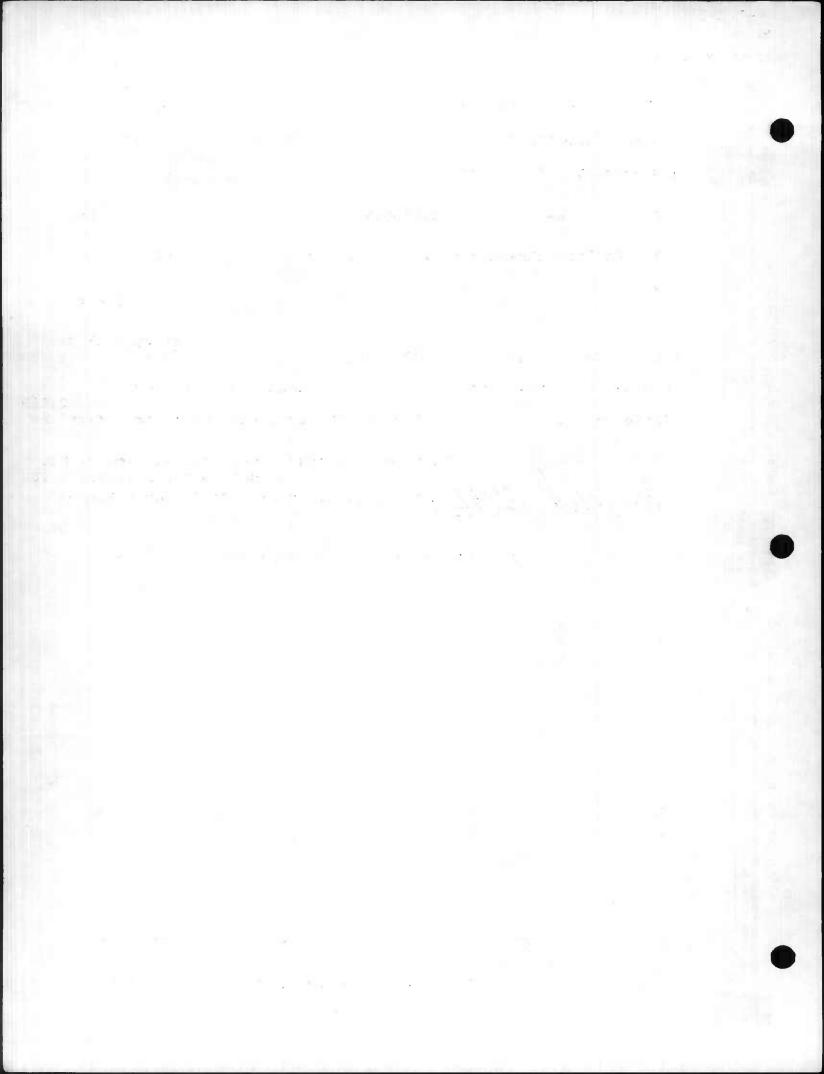
David

31. Date filed (Month, Day, Yeer)
SEP 2 1 1998

30. Name and eddress of person who completed cause of death (item 23a) (Type, Print)

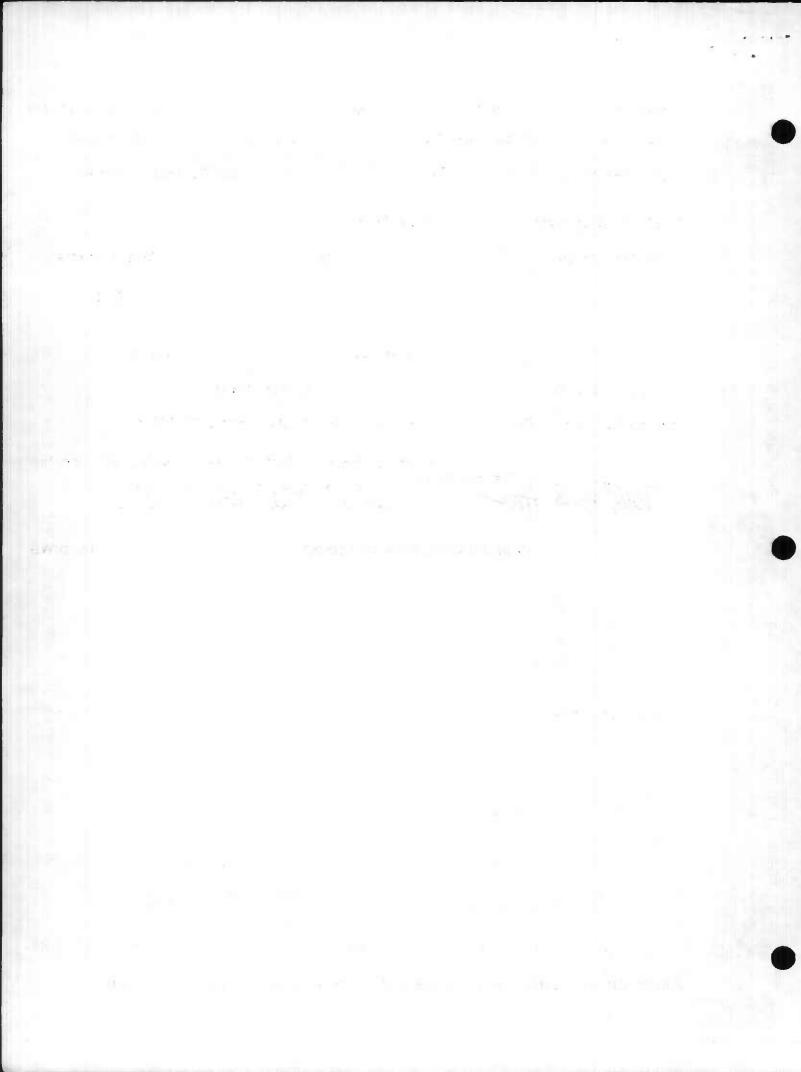
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32. Registrar's Signature



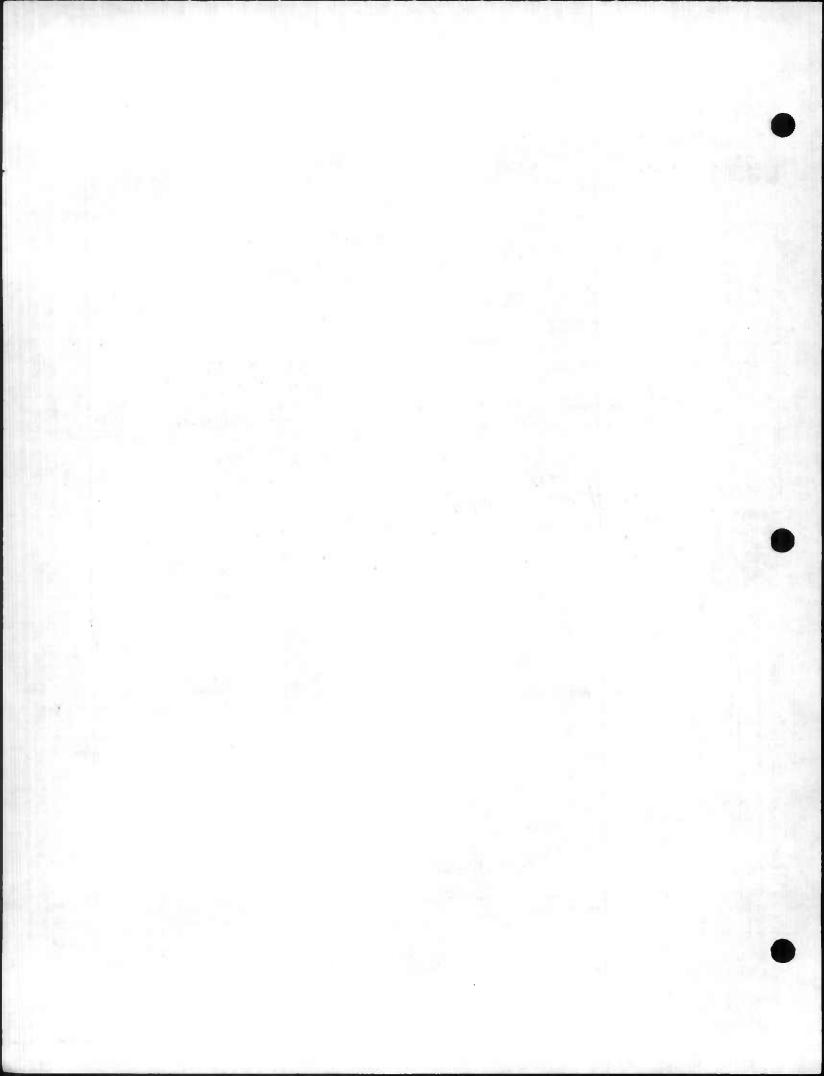
State of Maryland / Department of	of Health	and Mental	Hygiene
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Examine	er	,			,	ter		4				ath			mor	е
Funeral Director		5. Social Security Number 214-14-3543					If Under Months	1 Year Days	If Under:	24 Hrs. Min.	(Month,	Day, Y	ear) 1921	9. Birthe	place (Stanty)	te or Foreign
pue *	-	Usual Residence of Decedent  10a. State 10b. Coun	ntv		10c. (	City. Town or Le	ocation							T 1	0d. Insid	e City Limits
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28e	9	10e. Street and Number	TIIIO			IUIKV		Code				10g	. Citizen of \	What Cour	ntry?	
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urs efter deel al', or items	ò			Armed Fe 1 ☐ Yes If Yes, Gi	orces? 2 <b>∑</b> (No ive		if Yes, spec	ify Cuba	n, Mexican	gin? (Sp. , Puerto	ecify Yes or Rican, etc.)	Reg. No.  of Death the Day Year MBER 19 1998 4:15 AM Death 4c. County of Death Baltimore  of Birth 10, Day, Year)  Naryland  10d. Inside City Limits 1 Yes 2X No  10g. Citizen of What Country?  United States  14. Race - American Indian, Black, White, etc.  Specify: White  16b. Kind of Business/Industry  Own Home  Middle, Maiden Surname)  Number, City or Town, State, Zip Code)  Maryland  United States  14. Race - American Indian, Black, White, etc.  Specify: White  16b. Kind of Business/Industry  Own Home  Middle, Maiden Surname)  Number, City or Town, State, Zip Code)  Maryland  Uneral Home Imore, MD 21234  20c. Location - City or Town, State  198 Glen Burnie, Maryland  Uneral Home Imore, MD 21214  Approximate Indexial Between Onset and Death  16 DAYS  DAYS  DO Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown  1 Was en autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Conly one)  Residence 6 Other (Specify)  Scribe how injury occurred  ation (Street and Number or Rural Route Number, for Town, State)  to the cause(s) and menner es stated.				
within the	Popartize that the death cartificate be executed a popartize that the death cartificate be executed by the attending physician and large the death with the Maryland Mariet by Section and the filed within 72 hours efter death with the Maryland Mariet by Section and Department of Health and Mariet by Mysician and Department of Health and Mariet by Mysician and Department of Health and Mariet by Section and Department of Health and Department of Healt	(Specify only high Elementary/Secondary (0-12	hest gr	ade completed)		(Give	kind of wor DO NOT us	k done d e retired	ation fu <i>ring most</i> )	of work	ing	16			dustry	
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Mal d 2 sh h and 7 Is rr traum								-							Code)	
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ages ant of t: If It		1 X Burial 2 ☐ Cremetion			Siale					ا ماد	/21/0					
Daltit pemit. P Departme Importan any Injur				-		arman 2	eonar	d Addres	ss of Facilit	, Ir	ic. Fu	nera	al Hom	e		yranu
	+	23a. Part1. Enter the diamese.	or com	plications that	caused the de	ath. Do not en	305 Hater the mode	arto e of dyin	ra Ko g, such es	ad cardiac	Balt1 or respirator	MOP (	e, MU	21214	Approx	mete
		Immediate Ceuse (Final diseese or condition	ist only												Onset a	and Death
E HUE	Jer	resulting in death)		a	Due to	(or as a conse	quence of):									mete Between and Death DAYS
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	5	b												
BOX 58/5U, sath certificate be ax attending physician of for use as the bunal	VMedica	that initiated events resulting in death) Last	Initial Status	Ot eu C	(or es e consec	quenca of):										
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d by th				contributing to a	ributing to death but not resulting in the underlying cause given in Part I.						The second secon					
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I or Attending P offer death.  Director: After the by the funeral of the funeral	lcation:	2 ☐ Accident Invest	stigatio	DO DIO			М	10		No			Jay Year 1998 4:15 AM  4c. County of Death Baltimore  9. Birthplace (State or Foreign County) 1921 Maryland  10d. Inside City Limits 1 Yes 2X No  2. Citizen of What Country?  United States  14. Race - American Indian, Black, White, etc.  Specity: White  3b. Kind of Business/Industry  Own Home  3den Surname)  City or Town, State, Zip Code) 21234  Dc. Location - City or Town, State  1en Burnie, Maryland  3l. Home e, MD 21214  Approximate Interval Between Onset and Death 16 DAYS  2 No 3 Probably 4 Unknown  16 DAYS  17 Yes 2 No  18 Legs and Number or Rural Route Number, State)  19 Legs (s) and menner as stated.  19 Legs (s) and menner as stated.  20 Location - City or Town, Day, Year)  21 Legs (s) and menner as stated.  21 Legs (s) and menner as stated.  22 Legs (s) and menner as stated.  23 Legs (s) and menner as stated.  24 Legs (s) and menner as stated.  25 Legs (s) and menner as stated.  26 Locate signed (Month, Day, Year)  27 Legs (s) and menner as stated.  28 Legs (s) and menner as stated.  29 Legs (s) and menner as stated.  20 Locate signed (Month, Day, Year)  21 Legs (s) and menner as stated.  24 Legs (s) and menner as stated.  25 Legs (s) and menner as stated.  26 Locate signed (Month, Day, Year)  27 Legs (s) and menner as stated.			
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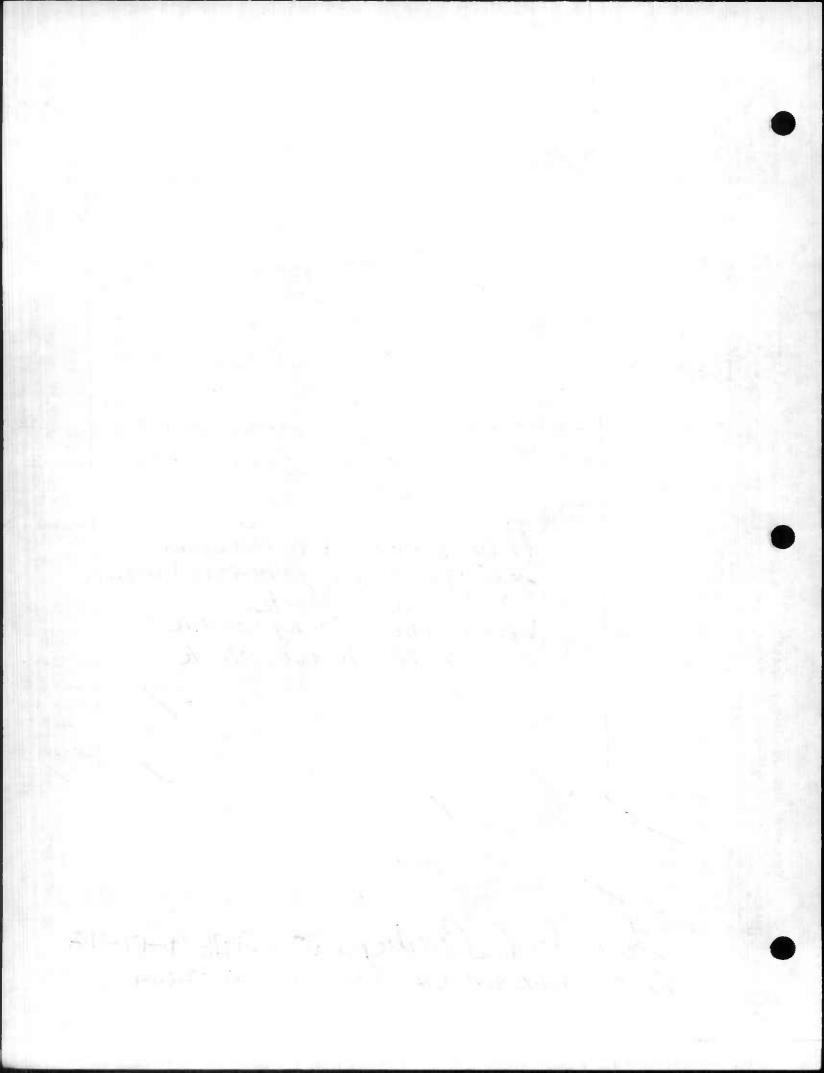
State of Maryland / Department of Health and Mental Hygiene

			C	ertificate of		Reg. I	20	28688
	ysician	Decedent's Nama (First, Middla, Last)     Thomas Cottman				2. Data of Death  Month  Sentember	Day Year	3. Time of Death 987:45p.m.
40.0	Medical kaminer	4a Facility Nama (If not institution, give street a Good Samaritan Hospit			4b. City, Town, or Lo Baltimore	cation of Death	4c. County of Dea	
	neral ector	5. Social Security Number 6. Sex X短M 2	7. Aga (In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day, Yea March 3,	9. Bir 1924 Va	thplace (Stata or Foreign ountry)
/and	H	Usual Residance of Decedant  10a. Stata 10b. County	10c. City, Town o					10d. Inside City Limits
se Men	ctor	Md. n/a	Baltimo					1 XXps 2 □ No
ath with th	iter must be notified at Funeral Director	10e. Street and Number 5004 Corley Road Apt.		10f. Zip Code 21207		US	Citizen of What Co SA	ountry?
5-0020 72 hours after death with the Menyland natural: or terms 23s or 28s-f show	by B	1 Navar Married 2 Married 15	s Decedant Evar in U,S.  Here of the control of the	13. Was Decedent of H If Yas, specify Cub 1 ☐ Yas 2 ☑ No	lispanic Origin? (Spe an, Mexican, Puarto Specify:	ecify Yas or No- Rican, atc.)	14. Race - Ame Black, White Specify: B	
15-0 72 ho		15. Decedent's Education (Specify only highast grada comp	elatad) (G	ecedent's Usual Occup liva kind of work done fa. DO NOT use retire	during most of worki	ing 16b.	Kind of Business	/Industry
Maryland 21215-0020 d2 should be filed within 72 hours aft th and Mentel Hygiene.	omp	Elemantary/Secondary (0-12) Col 9th Grade	loge (1-4or 5-)	nter		Fee	d. Tin &	Paper Prod.
yland 2  ould be filed  Mentel Hygi  arked other	9 % 0	17. Fathar's Nama (First, Middla, Last)  Ira Cottman			18. Mother's Name Annie But	(First, Middle, Maid	en Sumama)	
laryla 2 should end Men	traumatic	19a. Informant's Name/Ralationship (Type, Pri	nt) son/daughten	lailing Addrass (Street			y or Town, Stata,	Zip Code)
	other tra	Michelle Macklin/Ear		2 Marble Ha	all Road H			
Pages ent of rt: If it	5	20a. Mathod of Disposition  1 Septrial 2 □ Cramation 3 □ Remova 4 □ Donation 5 □ Othar (Specify)	I from State cematary,	on Forest	Veterans S	Sept. 18 0		ills, Md.
Baltii pemit. B Depertm Importer	any injury phos.	21. Signature of Funeral Service Liestings	Juny S.	22. Nama and Addra	ess of Facility Nut 5 Falls Ph	ter Funer WY Baltim	al Homes ore, Md.	s, Inc. 21216
		23a. Part1. Entar tha disaasa, or complications shock, or haart tailura. List only ona caus	s that caused the death. Do not a on again the	entar tha mode of dyir	ng, such as cardiac o	or respiratory arrest,		Approximata Interval Between Onset and Death
Physic /Med	lical	Immediata Causa (Final disassa or condition	Acute My	ocar dial	, Inhar	ction		1- 2 hrs
Exam		rasulting in death) a	Dua to (or as a cor		0	- (,= , =		
petho	tal-transit Examiner	Sequentially list conditions	A CIDOSIS  Dua to (or as a cor	nsequence of):				1
68760, ficate be exacut physician and	s the burial-transit	Sequantially list conditions, if any, leading to immediate cause. Entar Undarrying Cause (Disaase or Injury						
E 0	8	that initiated avants rasulting in death) Last	Dua to (or as a con	sequance of):				
Geath certi	Physician/M	Part tl. Other significant conditions contributing	g to death but not resulting in th	a undertving causa di	ven in Part i	23b. Did tobac	co use contribut	to the cause of death?
P.O.	Phys	Diabetes		1 □ Yes		Probably 4 Unknown		
of Vital Records, Physician: The lew requires the this certificate has been signed.	page 2 should be detached for use Completed by Physician/N	2 (Marco	Mellitus			24a. Was an au performed'		Wera autopsy findings available prior to completion of cause of death?
The lev ate hes	Page					1 ☐ Yas	2 No	1 ☐ Yas 2 ☐ No
of Vital   Physician: The	Be (	25. Was casa ratarred to medical axaminar?		O#	and the same of th	(Check only one)		
On of ding Phys h.	completaly filled in by the funeral director, page 2  Medical Certification: To Be Comp	DEL YAS ZLINO	1 ⊠opatient 2 □ ER/Outpa Data of Injury (Month, Day Year) 28b. Tim Inju	a of 28c. Injury	4 LI Nursing Ho	ma 5 Rasidence 28d. Dascribe how in		ecify)
To the Hospital or Attending I within 2 highest after death. To the Funeral Director: After	led in by the funera Certification:	2 Suiside 6 Could not be	Placa of Injury - At homa, tarm building, atc. (Specify)			28f. Location (Street City or Town, St	and Number or R ata)	Bural Routa Number,
Hospital of	pletaly fille edical C	(Check only 2 Medical Examiner: On	To the best of my knowledge, detection that has to see the basis of examination and/order manner stated.	eath occurred at tha tir r invastigation, in my o	ma, data and place, a opinion, death occurr	and dua to the cause ed at the time, date a	(s) and mannar a and place, and du	s stated. a to the cause(s)
To the within To the	Me	29b. Signatura and titla of certifiar		29c. Licens	se number	29d. I	Data signed (Mon	oth, Day, Year)
		1 allia	ii MD	)	1 1139.	8 Lep	lember	10, 1998
10x,		30. Nama and addrass of person who complate JIHAD AUHARINI,	d causa of death (frem 23a) (Ty Good Sam	pe, Print) anitan H	ospital.	, 5601 La	sel Rav	in, Day, Year) 10, 1998 -on Blvd
Re	State gistrar	31. Data tiled (Month, Day, Year) SEP 2 1 1998	32. Registrar's Signatura	boards				4



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middla, Last) 2. Data of Death **Physician** 9 998 6 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, giva street and number) 4c. County of Death Examiner ed enter If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days Months Hours 10 M 20 F Yrs. **Director** 213-32-7147 MD Usuel Residence of Deceder the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23s or 28s-f show Examiner must be notified at 1X Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death nent of Heelih and Mental Hygiene.
ant: if Hem 27 is marked other than "natural", or Hema 23.
ury or other traumatic event, the sending Exercise mainty or other traumatic event, the sending Exercise mainty. 124 W. Street apt 514 21201 Funeral Franklin 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Stetus 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes XXNo Specify: Specify: all þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8th grade 17. Fathar's Name (First, Middle, Last) Domestic na Private 18. Mother's Nama (First, Middle, Meiden Surnama) Be 2 Marris Coombs Violet Cooper 19e. Intorment's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other trai Amielier Horne-daughter 8106 Milford Garden Lane, Baltimore Md 21244 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 9/23/98 randallstown, Md 21. Signature of Funaral Service Licensee 22. Name and Address of Fecility earch F. H. West 23a. Pert1. Enter tha disease, or complications that caused the deeth. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart tailura. List only one cause on each line. Balto Md ZIZIS Wabash Svenue Approximate Intarvel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examir Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In daath) Last P.O. Box 68760 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 36 No 3 Probably 4 Unknown 1 Yee Records, þ 24b. Wera eutopsy tindings available prior to completion of cause of death? Be Completed 24a. Was en autopsy performed? The law 1□Yes 2□No 1 Yes certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient Certification: To 1 Yes 1 Inpatient 3D DOA 最 27. Marrier of Death 28e. Deta of tnjury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Affar or Attending Maturel 5 Pending 1 Yes 2 No death Investigation 2 Accident after death 6 Could not be determined 3 Suicida 28e. Plece of Injury - At home, term, street, tactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Steta) 4 Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29s. Certifier Medical (Check only 29b. Signature and tale of certific 29d. Date signed (Month, Day, Year) causa ot death (Itam 23a) (Type, Print address of parson who come onson 31 Deta tiled (Month, Dey, Year) 32. Registrats Signeture State SEP Registrar



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 7:00 AM William Н. Sept. 18, 1998 /Medical 4e Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baldwin Baltimore 14104 Quinn Lane If Under 24 Hrs If Under 1 Year 8. Dete of Birth May 21, Year 30 9. Birthplace (State or Foreign Mary Tand 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Months 1€ M 2 F 68 Yrs Director 216-28-4021 Usual Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits Examiner must be notified at . bM Baltimore Baldwin 1 ☐ Yes 2 ☑ No Director 28a-f 1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23s or Funerai 14104 Quinn Lane 21013 U.S.A. deeth Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Meritel Status 72 hours efter 1 ☐ Never Merried 2 ☐ Merried NOYes 2□No If Yes, Give Year or Detes: Korea Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: p Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "neny injury or other traumatic event, the Med Elementery/Secondery (0-12) College (1-4or 5+) 4 Civil Engineer Construction 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis A. Ennis Elizabeth Grady 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Katherine Ennis/Wife 14104 Quinn Lane Baldwin, Maryland 21013 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Buriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Dulaney Valley Mem. Grd. 9/21/98 Timonium, Maryland 22. Name end Address of Fecility 21. Signature of Funeral Service Lion Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23e. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. **Physician** Immediete Cause (Final diseese or condition resulting in deeth) /Medical 6 went Examiner Physician/Medical Examiner The law requires that the death certificate be asscuted attending physicien and for use as the burial-tran-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of). Box 68760, that Initieted events resulting in death) Lest Due to (or es e consequence of) P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown signed t Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy 1 Yes 20 No 1 Yes 2 No this certificata Division of Vital Aftending Physician: director. Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospitel: Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA led 4h by the funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation ≯ Netural deeth. 1 ☐ Yes 2 ☐ No 2 Accident i or Attend after deeth Director: 6 Could not be 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner as stated.
2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end menner steled. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number 18 020396 m 1)

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State Registrar

**DHMH 16 Rev 6/95** 

31. Dete filed (Month, Dey, Year) SEP 2 1 1998

30. Neme end address of person whar

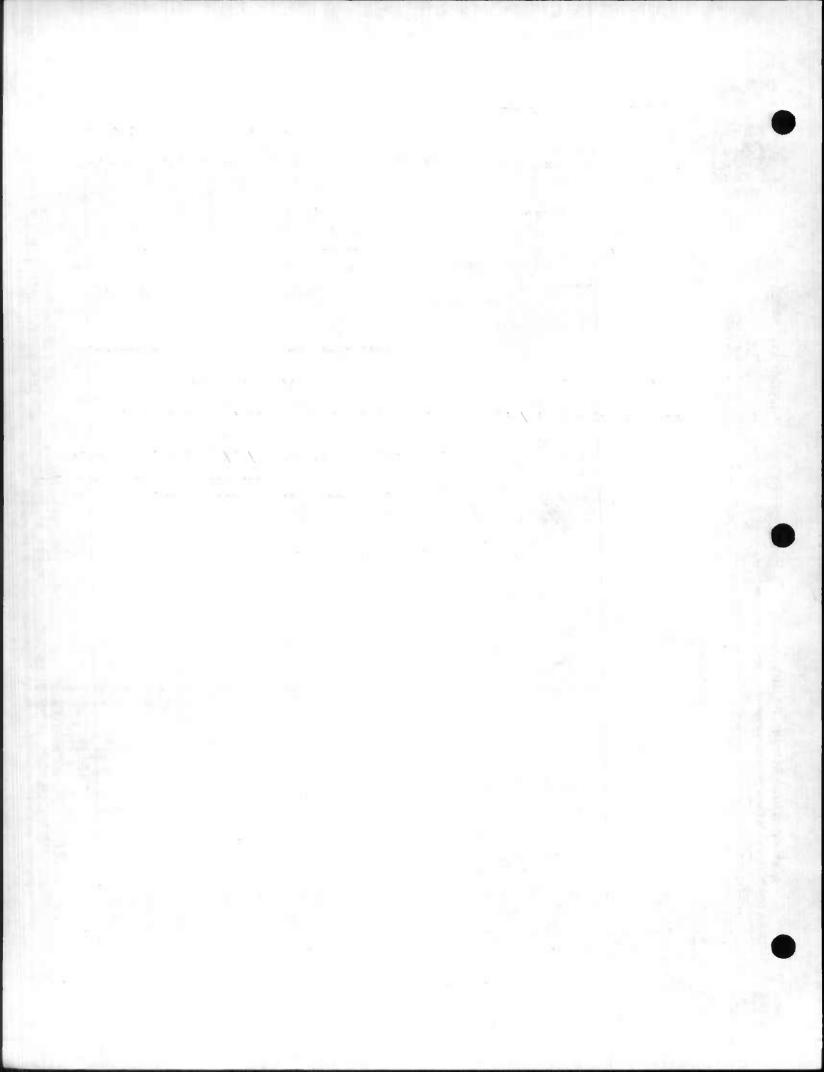
Davis

32 Registrar's Signeture

mpleted cause of deeth (Item 23a) (Type, Print)

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Examiner Examiner attending physician and for use as the burlai-transit 68760. Box Records, this

028-34-6473

**Physician** /Medical

> Physician/Medical 2 Completed Be Certification: To death.

Physician

/Medical

Examiner

**Funeral** 

Director

r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filled within 72 hours after death 1 Department of Hasilih and Mental Hygiens. Important: if item 27 is marked other than "natural".

Director

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Completed

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FORSTING Division of Vitai Attanding Physician: Hospital of Al 24 hours after Funeral Direct Vithin 2 To the

> State Registrar

edical

29a. Certifier (Check only one)

29b. Signature and title of certified

0/0 30. Name and address of person who come

> MD ala 614

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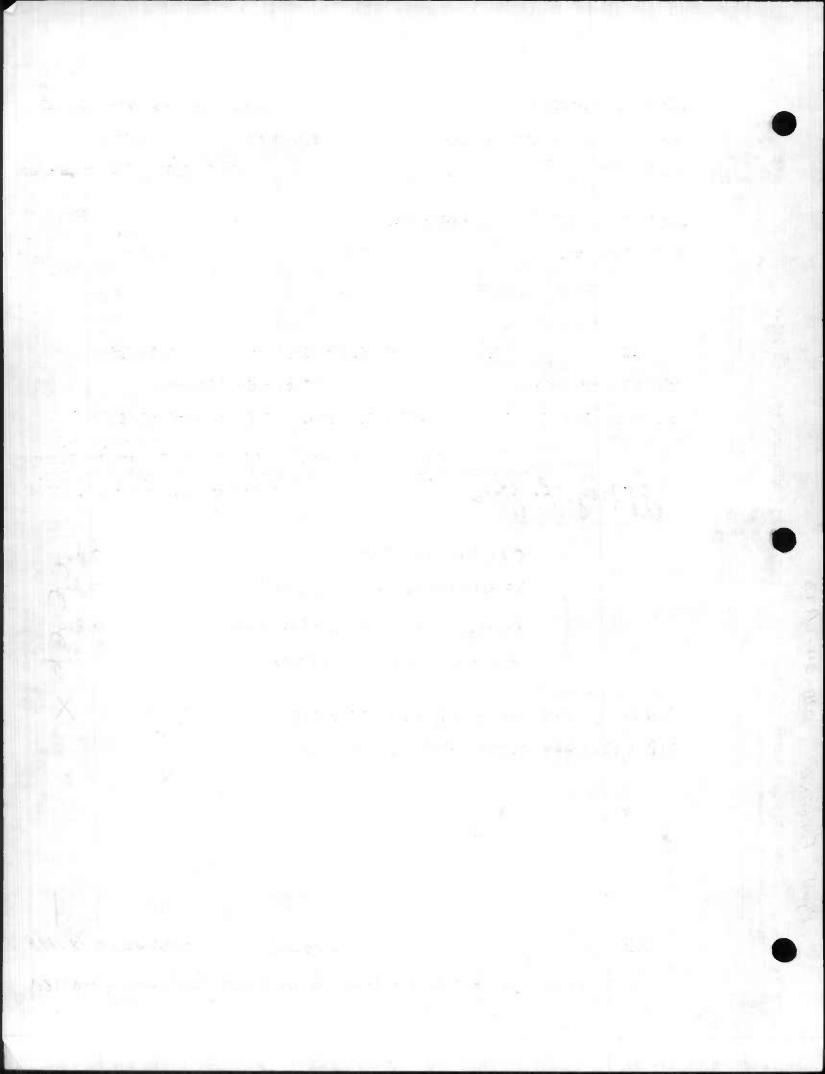
Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination end/or Invastigation, in my opinion, death occurred at the time, date and placa, and due to the ceusa(s) and mannar stated.

29c. License number

29d. Dete signed (Month, Day, Year)

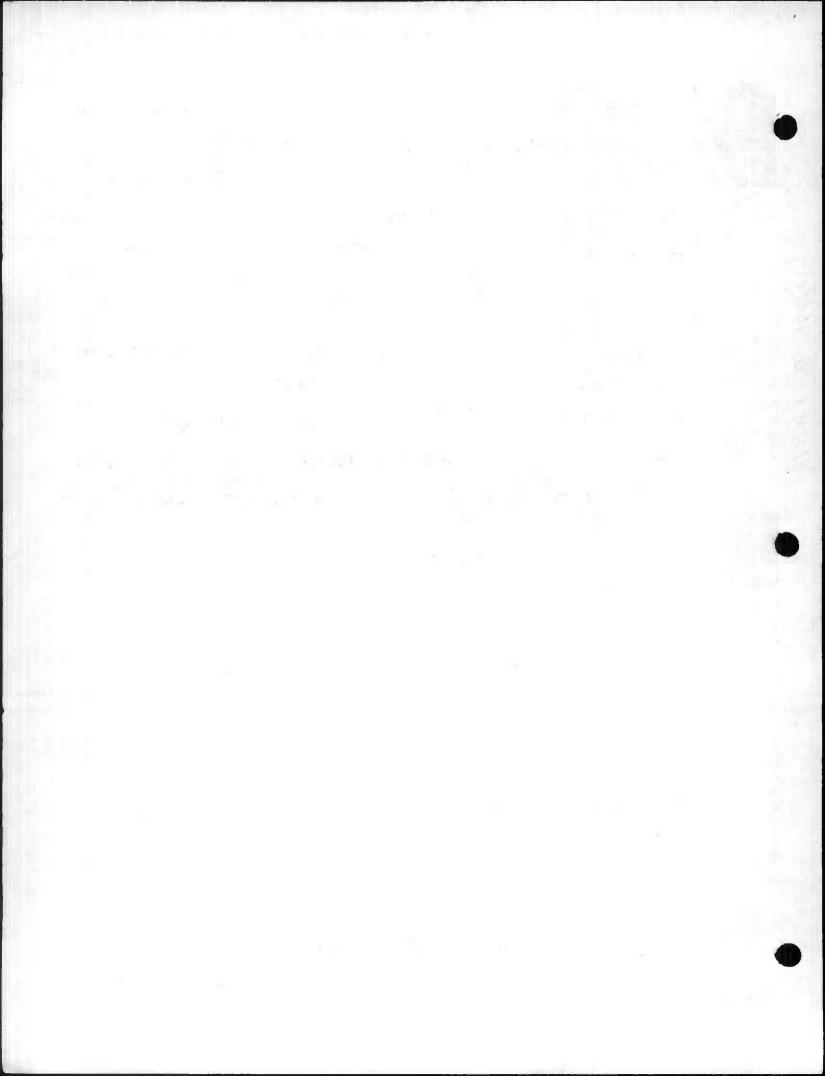
SEPTEMBER 17, 1998



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death Month Day 16, 1998 **Physician** Mary S. Fauntleroy /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** n/a Unnd General actimore OSPITAL 5. Social Security Numba 219-12-7217 If Under 1 Yeer if Undar 24 Hrs. Birthplaca (State or Foreign Country) (In yrs. last birthdey) **Funeral** Days 1 M 2 DO Yrs. Director July 15, 1923 Va. Usuel Rasidanca of Dacadant the Maryland 10a Stata 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at 10d. Insida City Limits Md. n/a Baltimore XXYas 2 No Director 10e Street and Numbe 10f. Zip Code 10g. Citizan of What Country? 2008 N. Dukeland Street 21216 USA Funeral 12. Was Dacedant Ever in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Bleck, White, atc. 1 Nevar Married 2 Married 1 ☐ Yas 2 ☐ No If Yes, Give 1 Yas 25 No þ Specify: Black 3 Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Baltimore City Elamantary/Secondery (0-12) Collaga (1-4or 5+) Cafeteria Worker Public Schools 8th Grade 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meldan Surnama) Andrew Sebree Jessie Wonson 19e. Informent's Name/Ralationship (Type, Print) daughter 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stete, Zip Coda) Frances L. Wilson 108 N. Culver Street Baltimore, Md. 21229 20a. Method of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata Burial 2 Cremation 3 Ramovel from Stata
Uponation 5 Other (Specify) Arbutus Memorial Park Sept. 23 Baltimore, Md. 22. Nama and Addrass of Facility Nutter Funeral Homes, Inc. 21. Signature/of Funerei Service Licens, 23a. Par I. Entar the disease, or complications that car led the death. Do not entar the mode of dying, such es cardiec or respiretory errast, shock, or heart failure. List only one cause on exhibited 2501 Gwynns Falls PKWY Baltimore, Md. 21216 **Physician** /Medicai Immediate Causa (Final disaase or condition rasulting in death) Examiner Dua to (or as a consequence of) physician and s the burial-transit Sequantially list conditions, if any, leading to immadiate causa. Entar Underlying Causa (Disaasa or Injury thet Initiated avants rasulting in daath) Lest east Failure Box 68760. Physician/Medicai tive Pulmonary Disease esn Part ii. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. the 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ should be 24b. Were autopsy findings eveilebla prior to complation of causa of daath? Completed 24a. Was en eutopsy been certificate has 1 Yas 2 No 1 ☐ Yas 2 ☐ No Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certific. 25. Was case rafarrad to medical axaminar?
1 ☐ Yas 2 ☑ No 26. Placa of Daath (Chack only ona) Hospital: 1 Inpatiant 2 ER/Outpetient 3 DOA Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) funeral 28a. Date of Injury (Month, Dey Yaar) 27. Menner of Death 28d. Dascribe how Injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Panding 1 Natural 1 Yas 2 No investigation 2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28a. Plece of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) filled in by 4 Homicida 29a. Certifier 112 Certifying Physicien: To the best of my knowladga, death occurred at tha tima, date and plece, end dua to the ceusa(s) end mannar as stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and dua to the causa(s) end manner stated. 29b. Signatura and titla of certifier 29d. Dete signed (Month, Day, Year) , M.D. 30. Name and address of person who complated cause of deeth (Item 23e) (Type, Print)

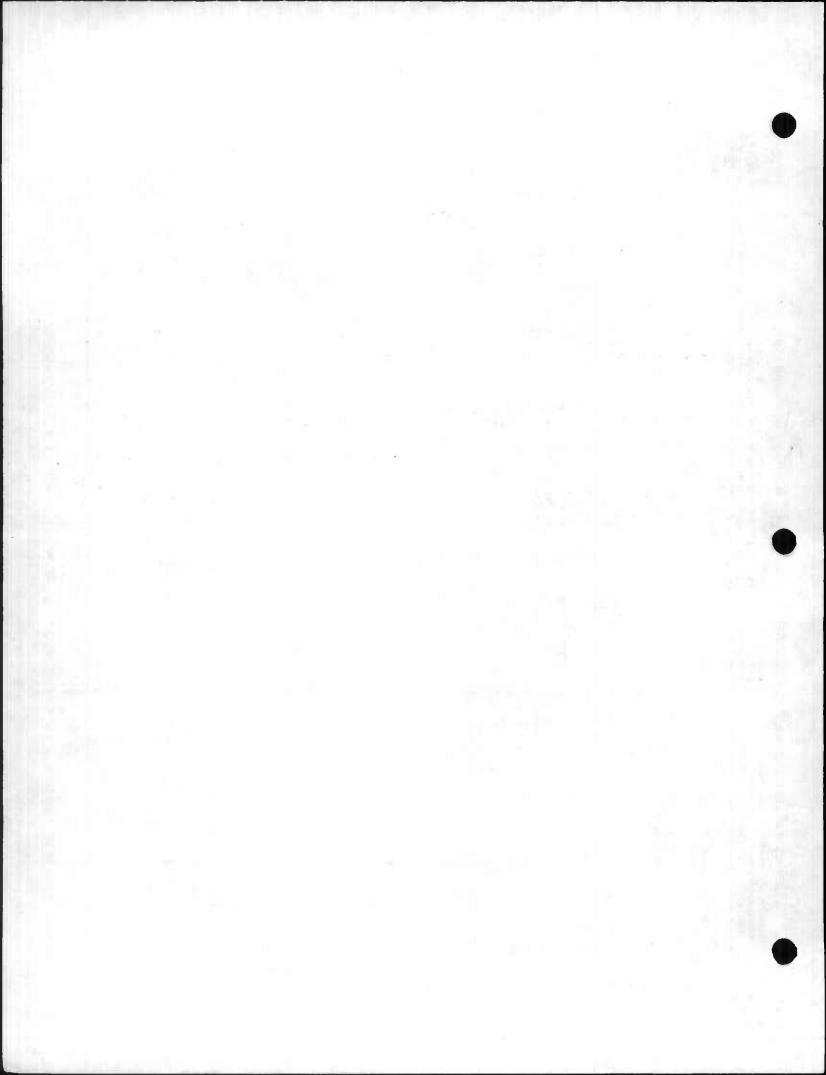
A. TMAL GILANI, M.D. CO Maryland General Hosp-tal 32. Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Nama (First, Middle, Last)	2. Data of Dea		28693								
hysician	ALVIN FITTS	Month	Day Ye	981:20PM								
/Medical xaminer		, or Location of Death	4c. County of E	Deeth								
	NORTHWEST HOSPITAL CENTER RAND	ALLSTOW										
eral ctor	212-20-7044 XAW 20 P 07 Yrs.	Min. (Month, Day	Year) 9. 7, 1930 M	Birthplace (State or Foreign Country)								
	Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits								
1	Md. n/a Baltimore			1 ☐ Yes 2₹ No								
recto	10e. Street and Number 10f. Zip Code	1	0g. Citizen of Wha	t Country?								
Q le	911 Scotts Hill Drive 21208		USA									
by Funeral Director		? (Specify Yes or No- uerto Rican, etc.)		American Indian, Vhita, etc. Black								
			16b. Kind of Busine									
Completed	(Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired)  Elementary/Secondary (0-12) College (1-4or 5+)	working	JS Govern									
E O	11th Grade Graphics	T.	Fort Mead	e								
Be	17. Father's Name (First, Middle, Last) 18. Mother's	Name (First, Middle, I	Maiden Sumeme)									
P	Curtis French Fitts Inez H	loward										
P	19a. Informant's Name/Reletionship (Type, Print) Bro./Sis. 19b. Meiling Address (Street and Number of											
	Floyd Fitts /Janie Skinner 3814 Cranston Avenu		<u> </u>									
	cemetery, cremetory or other place)		20c. Location - City									
		s Sept. 24	ept.22 Owings Mills, Md.									
	21. Signeture of Funeral Service Licensee  22. Name and Address of Facility  Nutter Funeral Home											
	2501 Gwynns Falls PKWY Baltimore, Md. 21216											
n al	shock, or heart failure. List only one cause on each line.  trimmediate Cause (Final disease or condition  PINEUMIA	Approximate Intervel Between Onset and Death										
' II	resulting in death)  Due to (or es a consequence of):											
iner iner	SEPSIS											
Examine	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying			- 1								
	Cause (Disease or injury											
edical	that initieted events rasulting in death) Last Due to (or as e consequence of):			8-1								
-	d											
olar	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	l age folder										
hys	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	but not resulting in the underlying cause given in Part I. 23b. Did tobacco u										
y P	HYPERTENSION	_   ""	- LE 110 5									
Completed by Physician/M	SJOGREN'S SYNDROME	24a. Was a perfor		4b. Ware autopsy findings aveilable prior to completion of causa of death?								
E		1 D Y	es 2 No	1 ☐ Yes 2 ☐ No								
Bec	25. Was case referred to medical 26. Place of	Death (Check only on										
To B	examiner? Hospital:			Specify)								
	27. Manner of Death  1   S   Netural   5   Pending   2   Accident   Accident   Pending   28a. Dete of Injury   28b. Time of thijury   28c. Injury at Work?    Manner of Death   28c. Injury at Work?   1   Yes 2   No	28b. Time of tojury 28c. Injury at Work? 28d. Describe how injury occurred										
Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location (Si City or Town		or Rural Route Number,								
edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and p 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of end manner stated.	lace, end due to the coccurred et the time, d	ause(s) end menne late and plece, end	er as stated. due to the cause(s)								
E 8	29b. Signeture and titla of certifier  ► 1		19d. Data signed (N EPTIZM	Nonth, Day, Year) 13 ER 16,98								
	30. Nema and address of person who completed cause of death (Item 23a) (Type, Print) 1 < . S . R											
	NORTHWEST HOSPITAL CENTER RAND	ALLST	own r	10.								
State	31. Dete filed (Month, Day, Year) 32. Registrar's Signature											

Registrar DHMH 16 Rev 6/95



98-5478-005

#### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

**JOHN** 

FINK JR.

State of Maryland / Department of Health and Mental Hygiene Items: 23 part I, II, 27 per MEO G-763 9/29/ Bertificate of Death

28694

**Physician** /Medical **Examiner** 

**Funeral** 

Director

Director Funerai þ

Completed

Be 2

I 2 should be filled within 72 hours after deeth with the Maryland n and Mental Hygiene.
Is marked other than "natural", or flema 23s or 28s-1 show raumatic event, its Modical Examiner must be notified as

laryland 21215-0020

Division of vital Records, P.O. Box 68/60,	F	baltimore, n
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	Phys /Mo Exa	Depermit. Pages 1 end Depertment of Health
To the Funeral Director: After this certificate hes been signed by the ettending physician and	sic ed mi	Important: If item 27
completely filled in by the funeral director, page 2 should be detached for use es the bunal-fransit	iai ica ne	any injury or other t
	n il r	ouce.
Medical Certification: To Be Completed by Physician/Medical Examiner		

. Decedent's Nam	e (First, Middl	e, Last)									Voor	3. Time of Death	
John	A116	en		Fink	]	III						2.55P.M.	
a Facility Name (	lf not institution	n, give street and n	um <i>ber</i> )				4b. City, To	own, or L	ocation of Dea	th 4c. County	y of Death	h	
3500 CHES	STNUT O	AK ROAD					Park	cvil.	le	BALT	IMOR	E	
. Social Security N	lumber	6. Sex	7. Aga	(In yrs. last	birthday)				8. Data of B	irth Vacal	9. Birtl	hplaca (State or Foreign	
216 36 6	349	1∭ M 2□ F	- 4	58	Yrs.	Months Day	rs Hours	Min.	Feb. 2	6. 1940	100		
Jsual Residence of										,	Ma	LYTAIL	
0a. State	10b. County			10c. City, To	own or Lo	cation						10d. Inside City Limits	
Maryland	Ba1t	cimore				Balti	more					1 ☐ Yes 2 No	
0e. Street end Nu	mber					10f. Zip Code				10g. Citizen of	What Co	untry?	
8500 Che	stnut (	Dak Rd.,	Apt.	1			21234			United	d Sta	ates	
1. Marital Status				ver in U,S.	13. \	Vas Decedent of	f Hispanic Or	igln? (Sp	pecify Yes or N				
1 Nevar Marr	ied 2 Man	ried 1 ☐ Yes	2 N	o					riioari, oto.j				
3 ☐ Widowed 4XD ivorced If Yas, Giva Year or Dates:						I Yes 21XN	o Specify:			Specil	у:	White	
(Sne/	15. Deceden	it's Education st grade completed	()	19	6a. Deced	lent's Usual Occ	cupation	t of work	kina	16b. Kind of B	usiness/	Industry	
Elementary/Seco				+)	life. L	OO NOT use ret	ired)						
12		2			Com	mercial	Fisher	man		Seafoo	d Inc	dustry	
7. Father's Name	(First, Middle,	Last)					18. Moth	er's Nam	ne (First, Middle	e, Ma <i>iden Sur</i> nar	me)		
John	A11	Len		Fink,		Jr.	Marg	gare	t		Sta	fford	
19a, tnformant's N	ame/Relations	ship (Type, Print)		1	9b. Meilir	g Address (Stre	et and Numb	er or Ru	ral Route Num	ber, City or Town	, Stete, Z	Zip Code)	
Michelle	Munoz	/ Daught	er		6 Bes	cleigh (	t., Ap	ot.	104, Ba	ltimore	, MD	21234	
Oa. Method of Dis	position			20b. Piece	of Dispo	sition (Neme of	iace)		Dete	20c. Location	- City or	Town, State	
1 Donation	Cramation 5 Other (S	3 □Ramoval from loacify)	n State					9/	21/08	Ral+i	mora	MD	
21. Signature of Fu				OLCCI			_		21/ 30	Darti	HOLE	, 110	
N 524	-1 (A)	40											
- Ou	sund	Loture	em								re, l		
23a. Part1. Enter f shock, or hea	he disease, or at failure. List	complications that only one cause on	each lin	the death. De.	o not ent	er the mode of o	lying, such as	cardiac	or raspiratory	arrest,		Interval Between	
												Onset and Death	
Immediate Cause disease or condition	(Final In	ATHE	ROSCL	EROTIC	CARDI	OVASCULAR	DI	SEASE			1		
resulting in death)		<b>a</b> .		Due to (or as	or as e consequence of):								
Sequentially list co	nditions,	6.	[	Due to (or as	a conseq	uenca of):					1		
f any, leading to in cause. Enter Unde Cause (Disease or	nmediate										1		
thet initieted events	5	С.	0	Oue to (or as	a conseq	uenca of):			Ac. County of Death   10   10   10   10   10   10   10   1				
resulting In death)	Last		Fink III    Ab. City, Town, or Location of Death Parkville   Parkv										
		d											
Part II. Other signif	tcant conditte	ons contributing to	death bu	t not rasultin	a in the u	nderiving cause	given In Part	l.	23b. Dtd	tobacco usa co	ontribute	to the cause of death	
					g (r.o u	y was	g o art					robably 42 Unknow	
CHRONIC	UNSTRUC	TIVE PULMON	ARY D	DISEASE							-2.	2	

25. Wes case referred to medical axaminer? 3□ DOA 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 27. Manner of Death 28a. Date of fnjury (Month, Dey Yeer) 28b. Tima of 1 D Natural

5 Pending investigation 6 Could not be determined

28e. Piece of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, State)

28d. Describe how Injury occurred

1 Yes 2 □ No

24e. Wes an autopsy performed?

Other: 4 ☐ Nursing Home 5 🎇 Residenca 8 ☐ Other (Specify)

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner es stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29c. License number

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to complation of causa of death?

1. Yes 2□ No

30. Name and address of person who completed cause of death (Item 25a) (Type, Print)

O.C.M.E.

SEPTEMBER 18,1998

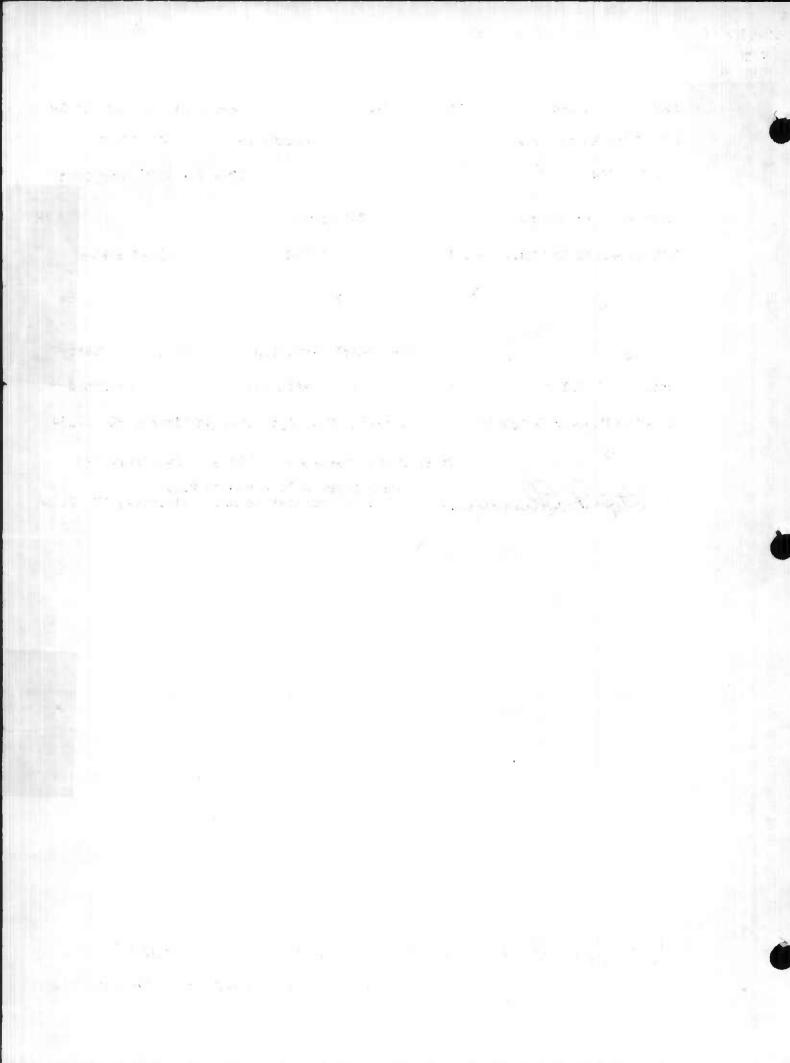
Radentz 5

111 Penn Street, Baltimore, Maryland 21201

26. Place of Death (Check only one)

State Registrar

32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey SEPTEMBER 13,1998 **Physician** -ORETTA HOLMES 11.08 PM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTER HARBOR HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2 F Months 219-48-1716 October 10,1942 MARY LAND Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show 10a. Stete 10b. County 10d. tnside City Limits NA BALTIMORE 1 XYes 2 □ No MARYLAND Director 10e. Street and Numbar 10f. Zip Code 10g. Citizen of What Country? 6 611 3. CHARLES STREET U.S.A. 21236 Nerna 23a 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Status Black, White, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 8 1 ☐ Yes 2 1 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☑ Divorced "natural". 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 1 and 2 should be filed within Health end Mental Hygiene. em 27 is marked other than " Elementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER DWN HOME 12TH GRADE 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) HOLMES CALVIN CUSTIS FLORFNCE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health en Important: if Nem 27 Is s any Injury or other trau 4604 YORK ROAD, BALTIMORE, MARYLAND 21212 KONALD MILLER JR. (SON) 20b. Placa of Disposition (Name of cemetery, cremetory or other placa) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ■ Buriel 2 □ Cremetion 3 □ Removel from State 9-21-98 LANSDOWNE, MARYLAND MT. ZION CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility JOSEPH H. BROWN JR. FUNERAL HOME Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate Approximate Intervel Between Onset and Death **Physician** PNEUMONIA Immediate Cause (Final disease or condition resulting in deeth) /Medical SEPSIS Days Examiner Examiner CERERO VASCULAR ACCIDEN Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as e consequence of): Physician/Medical Due to (or es e consequence of): P.O. Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown FAILURE HERRI Records, þ Completed

DIABETES MELLITUS

TRACT URINKRY

24a. Wes an autopsy performed? 24b. Were eutopsy findings available prior to

completion of cause of death?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one)

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Menner of Death

5 Pending Investigation 6 Could not be determined

28e. Date of Injury (Month, Day Year)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 Accident

3 ☐ Suicide

4 ☐ Homicide

Be

edical Certification:

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner stated. 29d. Dete signed (Month, Day, Year)

29b. Signeture end title of certifier eepak

29c. License numbar

SEPTEMBER 14.

Registrar

DEEP MK KUMKR 31. Dete filed (Month, Dey, Year) SEP & 1 1998

Chuan M.D. 32. Registrer's Signature

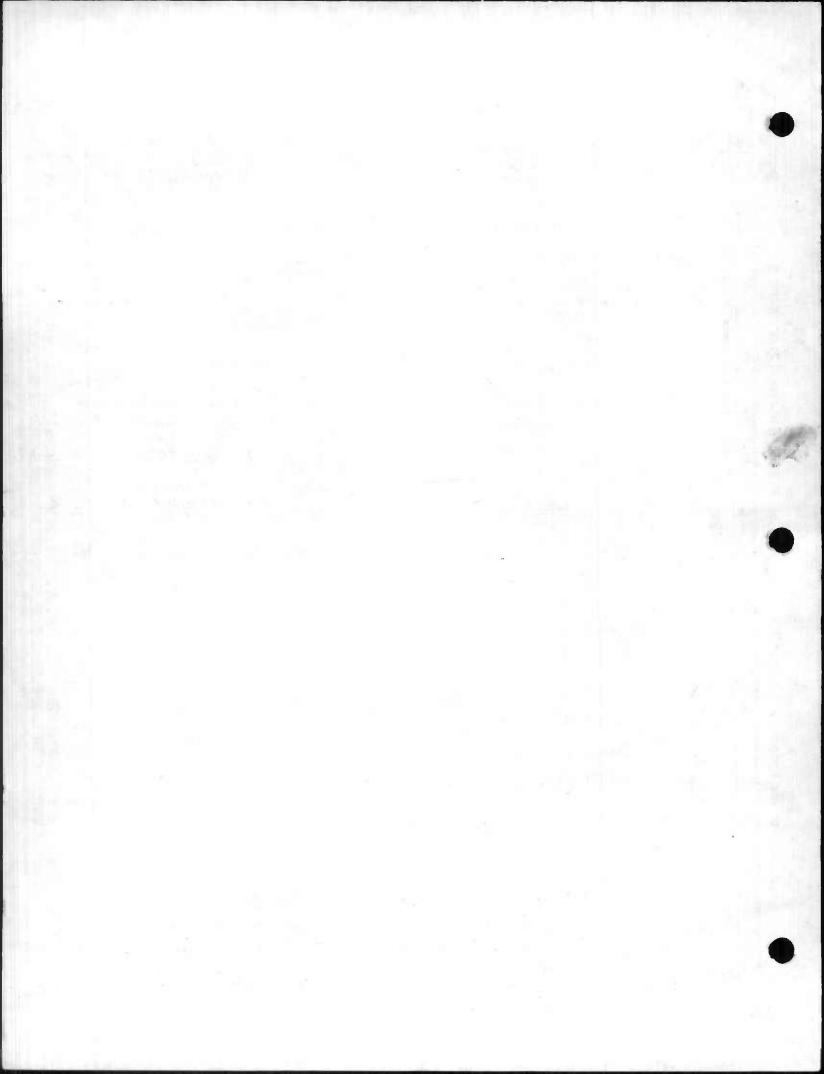
3001 S. HANOVER ST. BALTIMORE

Division of Vital

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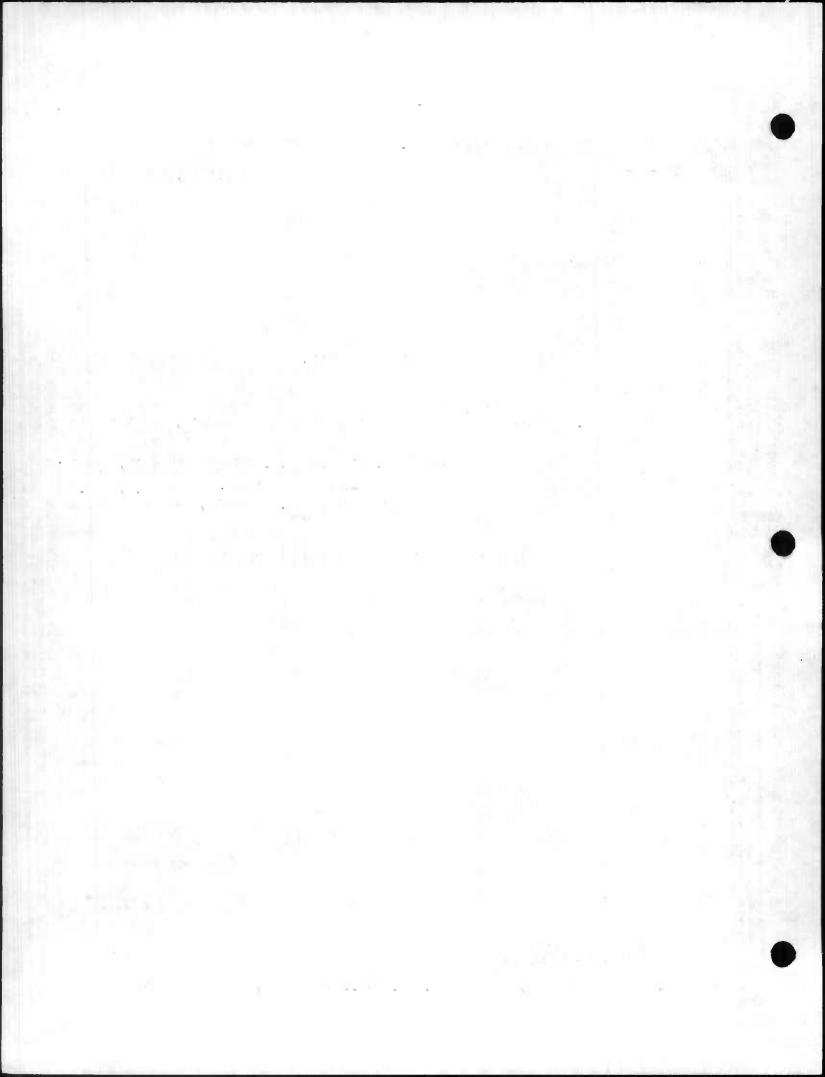
After !

To the Hospital or Attending Pl within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funera



State of Maryland / Department of Health and Mental Hygiene

			C	ertifica	ate of	Death		Reg. No.	286	96	
Dhusisian	1. Decedent's Neme (First, Middle, Las		34	,	Ih a.u		2. Dete of De Month		Year 3. T	ime of Death	
Physician /Medical		Margaret	М.	1	luber		Septe	mber 15		5:02AM	
Examiner	4e Facility Neme (If not institution, give	street and number)				4b. City, Town, or	r Location of Death	4c. County	of Deeth		
	Johns Hopkins Ba			1 //1			ore City		I/A		
uneral irector	212 20 00,2	ex 7. Age (In) □M 25⊋F 80	rrs. last birthda Yrs.	Month	ler 1 Year s Days		n. (Month, Da	th y, Year) 19, 1918	9. Birthplece (S Country) B Mary1		
	Usuel Residence of Decedent  10a. Stete 10b. County	100	City, Town or	ocation					10d Inc	ide City Limits	
ust be notified at		ltimore	Oxy, Town or	Location		Dundal	k			Yes XX No	
Director	10a. Street and Number			10f. 2	Zip Code			10g. Citizen of V	What Country?		
aic	1776 Stokesley	Road				21222		United	States		
by Funeral	11. Merital Stetus  1 Never Merried 2 Merried  3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	n U,S. 13		edent of I becify Cub 2 No		Specify Yes or No rto Rican, etc.)	- 14. Rec Bled Specify	a - American Ind ck, White, etc. : White		
Pe	15. Decedent's Ed	ucation	16a. Dec	edent's Us	suel Occup	pation	ards in a	16b. Kind of Bu	usiness/Industry		
Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	lifa.	DO NOT	use retire	during most of wo	urking				
Con	6 Years		Gif	t Sho	p Cl	erk		Hospita	al Gift	Shop	
B	17. Fether's Neme (First, Middle, Last)					18. Mother's No	eme (First, Middle,	Meiden Sumen	10)		
9	Clement Rupp				50.5	Mary					
	19e. tntorment's Neme/Reletionship (7										
	Catherine M. Jan					sley Roa	d Dunda	-		1222	
	20a. Method of Disposition  1 Buriel 2 Cremetion 3 4 Donetion 5 Other (Specify	Removal from Stete	b. Place of Disposer cometery, cr	emetory o	r other pia		Dete 9/18/98		City or Town, St		
	21. Signature of Fanegas Service Lippy			22. Neme	end Addre	ess of Fecility					
6	* hall	take					1 Home o				
	23a. Pert1. Enter the disease, or composhock, or haert feilure. List only of	plicetions that caused the d	eeth. Do not e	1922	oda ot dvi	e Ave.	Dundalk,	Marylar rest		zimeta al Between	
ong prysician and see as the burial-transit and AMedical Examiner	Cause (Disaase or Injury that initiated events resulting in death) Last  C. Due to (or es a consequence of):										
be detached for use by Physician/R	Death Other size Manager and Manager			ant put							
Physician/N	Part II. Other significant conditions co	ntributing to death but not	resulting in tha	undanying	cause gr	ven in Pert I.		23b. Did tobacco use contribute to the cause of			
Completed by								en eutopsy rmed?	24b. Were eut available complatio	prior to on of cause	
Com							10	Yes 2 No	1 ☐ Yes	2 No	
director, p	25. Wes casa refarred to medical					26. Place of De	eath (Check only o				
5	examiner?	Hospitel: 1 Inpatiant 2	ER/Outpati	ent 3XI	DOA OI	her:	Homa 5 ☐ Resi		er (Specify)		
	27. Menner of Deeth	28e. Deta of Injury (Month, Day Year	28b. Time	of	28c. Inju Wo			how injury occur			
cation:	1 Naturel 5 Pending 2 Accident investigation	(Morius, Day 1 6ar	) Injury	M		Yes 2 No					
一	3 Suicide 6 Could not be determined	28e. Plece of Injury - A building, atc. (Spe	t home, ferm, s	street, facto	ory, office		28t. Location (: City or Tot		per or Rural Rout	e Number,	
	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exam	reician: To the best of my iner: On the basis of exame and menner steted.	knowledge, dea inetion end/or	th occurre investigetion	ed et the ti on, in my d	me, date and pleo opinion, daath occ	ca, end due to the curred at tha tima,	ceuse(s) end me deta and placa,	enner as stated. and due to tha co	ause(s)	
Medic	29b. Signature end title of certifier			2	9c. Licens	se number		29d. Dete signe	d (Month, Dey, Y	(001)	
'	A.71 and 1/8	Edwards >	MM		N	211.01		9/1	190		
	30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)										
	Dr. Willarda Edwa		N. Pt		rd.	Baltimor	e, Maryl	and 212	224		
Chala	31. Dete tiled (Month, Day, Year)	32. Registrer's Sig		· DIV	1	Dartimol	e, maryi	unu 212	-44		
State Pegistrar	CED 2 1 10		~ /	9.	lone	161					



State of Maryland / Department of Health and Mental Hygiene 28697

		F- F-		Certif	ficate of I	Death			Reg. No.						
Physician	1. Decedant's Nama (First, Middla, Last)  2. Dete of Death  Month  Day  Year									3. Tima of Death					
/Medical		ouise Hunt					he	() em	ser 15,	1998	1731				
Examiner	4a Facility Nama (If not institution, gi	va street and numbe L County H			4		wn, or Locat ninste	tion of Deeth		y of Death					
Funeral		Sex 7. A	nga (In yrs. last bii	N	Undar 1 Yeer	If Under a	24 Hrs. 8. Min.	Data of Birt (Month, Da	h y, Yeer)	9. Birthy Cou	place (Stata or Fore				
Director	004-01-7552 Usual Rasidance of Decedant		85	Yrs.			Fe	b. 27	1913	Brewe	er, Maine				
yland	10a. Stete 10b. County		10c. City, Tow	n or Locat	ion						10d. Inside City Lim				
ctor	Md. Carro	11	Fi	inksb	urg						1 Yas 2 🔀				
or 28	10e. Street and Number				10f. Zip Coda	401.0			10g. Citizen of		ntry?				
23a vent	30240 Murray Ro					1048		U.S.A.							
ould be filed within 72 hours efter of Mertal Hygiena.  streed other than "natural", or itse actic event, the Medical Emorrae  To Be Completed by Fur	11. Marital Status  1 □ Naver Married 2 □ Marriad  3 ₺ Widowed 4 □ Divorced	12. Was Decedan Armed Forces 1 Yes 2 fill If Yas, Giva Yaar or Datas	? No		S Decedant of H as, specify Cube Yas 2 No	Specify:	gin? (Specif , Puerto Ric	y Yes or No- an, atc.)	Speci	ce - Ameri ack, Whita, fy: Wh:					
	15. Decedant's E		16a	. Deceden	t's Usual Occup	ation	t of working		16b. Kind of E	Businass/In	dustry				
	(Specify only highast gi	Collega (1-4o	r 5+)	lifa. DO	d of work dona on NOT use retired onemake:	1)	or working		Home	emaki	ng				
	17. Fathar's Nama (First, Middle, Las John J. 1			18. Mothar's Nama (First, Middla, Maidan Sumame) Margaret Murphy											
	19a. Informant's Name/Ralationship	(Type, Print)	198		Address (Streat										
end health	Richard J. Hunt	son	001 01		40 Murr	ay Ro			rg, Md.		048				
or off	20a. Method of Disposition	Ramoval from Stat	comete	ry, cramet	on (Nama of ory or othar plac	ce)		Date	20c. Location	- City or T	own, Stata				
man tant: jury	4 □ Donation 5 □ Other (Spec	ify)	Mt. P		nt Ceme		Sept.	. 24,	1998 I	Bango	r, Maine				
Christian Medical Medi	Immediata Causa (Final diseasa or condition rasulting in daath)  Sequantially list conditions, if eny, leading to immediata ceuse. Enter Undarlying Ceusa (Diseasa or Injury that initiated avants	a. Cen.	Dua to (or as a function of the function of th	consequal consaqual	blee nce of): nce of):	0					8 DAYS FDAY				
nding use a	d									Jt.					
death	Part II. Other significant conditions	contributing to daath	but not rasulting I	In tha unda	rlying ceuse giv	ren in Part f		23b. Dld	tobacco use c	ontribute t	o the cause of de				
es that the death cer igned by the attendin be datached for use by Physician/A	Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.  23b. Did tobacco use contribute to 1 Yes 2 No 3 Prot							bably 4 Unk							
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The lay								10	1 ☐ Yas 2 ☐ No 1 ☐ Yes 2 ☐ No						
certificate rector, peg	25. Was cesa rafarrad to medicel examiner?						of Death (	Check only o	ona)						
Physic this of rel dire	1 Yas 2 No	Hospital; 1 Inpa			3□ DOA Oth	4 L NU	-		dance 6 🗆 Of		(h)				
After fune	27. Menn of Death  1. Natural 5 Panding 2 Accident invastigation	28e. Date of In (Month, E	Jury 28b.	Tima of Injury	28c. Injur Wor M 1			d. Dascribe i	how injury occu	rred					
To the Hospital or Attending Physician: The I within 24 hours aftar death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page  Medical Certification: To Be Com	3 Suicide 6 Could not l	28e. Place of I						28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)							
To the Hospital or within 24 hours afta To the Funeral Direction Completely filled in Medical Cert		hysician: To the bes miner: On the basis end mannar:	of examinetion er												
withir To th comp	29b. Signeture and titla of certifier	Cuerty	les 1	M	29c. Licens	e number	21		Se Sign	ad (Month	Day, Year) 18, 199				
10	CALLOCE COL	completed ceusa of	MIAN	(Type, Pri	1000	-, u	vesti	NIVST	Ten 1	uan	4 (90 (				
State Registrar	SEP 2 1 1998	32. Regis	strar's Signature	ph	outs										

MARY LOUISS HUNT

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene GEORGE F. JACKSON ITEMS: #23 PART I.II. 27 PER MEO G764 10-14- Gentificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 3. Time of Deeth 2. Dete of Deeth Month Dev **Physician** JACKSON JR. FRANKLIN JEORGE SEPTEMBER 16, 1998 1153AM /Medical 4s Fecility Neme (If not institution, give street end number, 4b. City, Town, or Location of Deeth Examiner 3415 WABASH AVENUE BALTIMORE CITY Il Under 1 Yeer | Il Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 100M 20 F Months Days Hours 59 216-34-832 Usuel Residence of Decedent Yrs. DEC. 04, 1938 Director MARYLAND the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at Yes 2□No Director BALTIHORE MARYLAND 10e. Street end Number 10g. Citizen of Whet Country? 3415 21215 USA.

14. Rece - American Indien,
Bleck, White, etc. ABASH AVENUE Funeral death 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes 2 No II Yes, Give Yeer or Detes: 11. Maritel Status 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: BLACK Maryland 21215-0020 λq 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) DUPERVISOR 12 +HGRADE 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) permit. Pages 1 and 2 should be f Depertment of Health and Mental P Important: If Item 27 is marked or GEORGE FRANKLIN JACKSON SR. GUSSIE BOWLER 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 20b. Place of Disposition (Neme of cametery, crametory or other place)

STREET BALTIMORE Mb 3/3/17

20b. Place of Disposition (Neme of cametery, crametory or other place) MARK JACKSON (SON other 1 altimore. 20e. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removel from State Injury or ARBUTUS CEMETERY 9-21-98 ARBUTUS, HARYLAND 5 ☐ Other (Specify) 4 Donetic 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory direct.

Approximate

Approximate

Approximate 22. Name and Address of Fecility hu **Physician** /Medical Immediate Ceuse (Final diseese or condition resulting in death) e ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Examiner Due to (or as e consequenca of): Examiner physician and the buriel-transit certificate be executed Due to (or es e consequenca of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical thet initieted events resulting In death) Lest Due to (or as e consequenca ol): as esn ō signed by the a d be detached f 23b. Did tobacco use contribute to the cause of deeth? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. the 1 Yee 2 No 3 Probably 4 Unknown CROHN'S DISEASE à 24b. Were eutopsy lindings eveitebte prior to completion of cause of deeth? 24e. Wes en autopsy Completed has page 2 12 Yes NETYes 2 No 2 No certificete Division of Vital 25. Was case referred to medical exeminer? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) P 1 XYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28d. Describe how injury occurred uneral 28b. Time of 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? After f Certification: or Attending 5 Pending Investigation 1 X Naturel efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, lactory, office building, etc. (Specify) filled in by 4 Homlcide 24 hours r Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred et the time, date and plece, end due to the ceuse(s) end menner stated.

State Registrar

within 2. To the F 4

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HAMBRION 1. KOREW OM

O.C.M.E.

29c. License number

SEPTEMBER 17, 1998

29d. Dete signed (Month, Dev. Year)

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

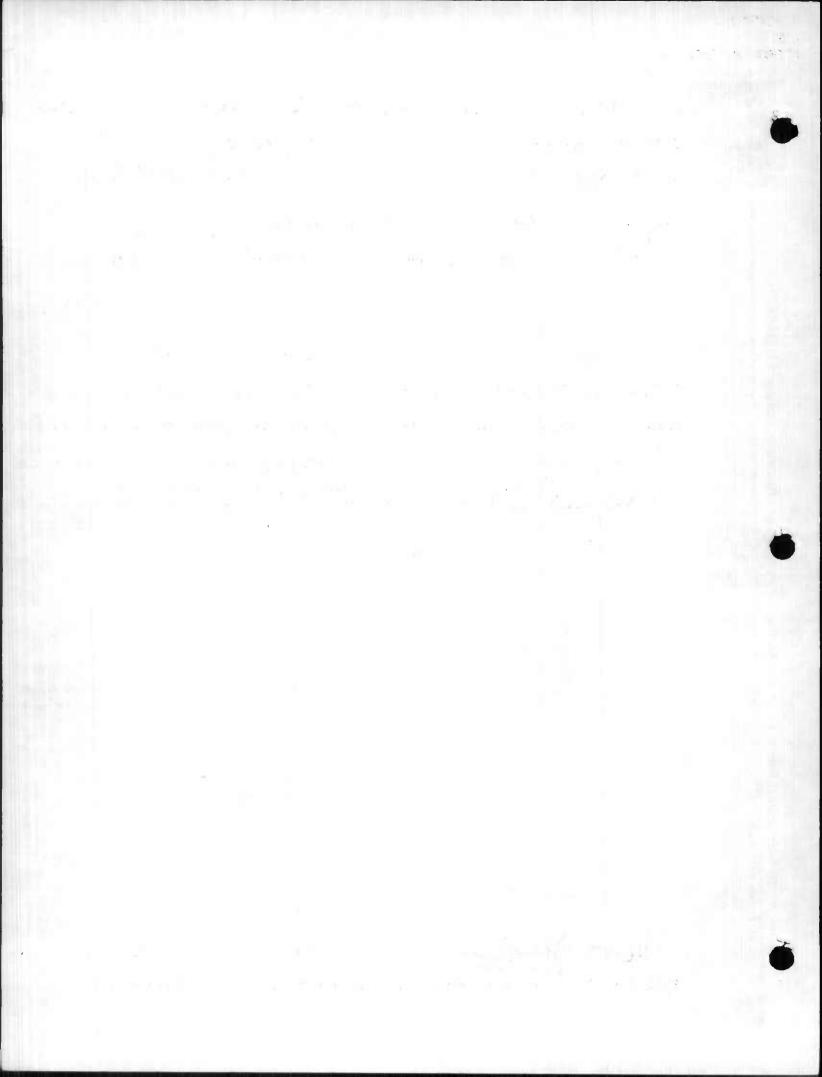
111 Penn Street, Baltimore, Maryland 21201

31. Date fited (Month, Day, Year) 32. Registrar's Signeture

Medical

29a. Certifier (Check only one)

29b. Signature and title of certif

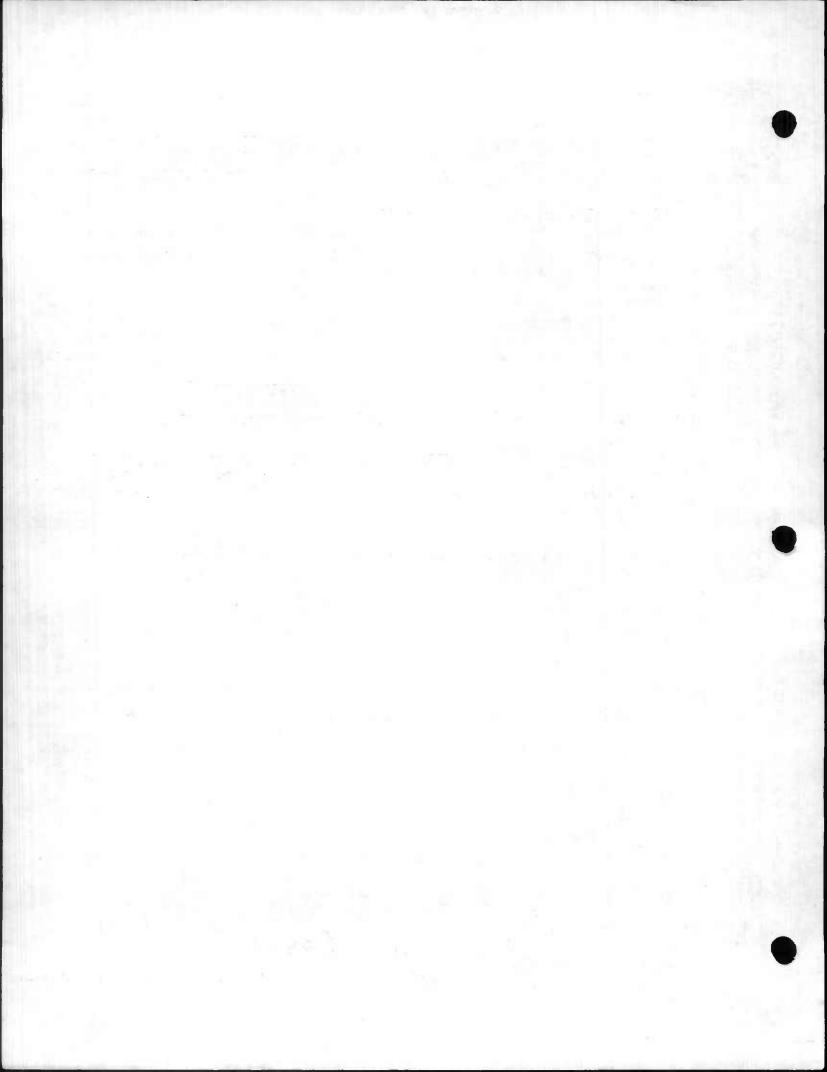


State of Maryland / Department of Health and Mental Hygiene

28699 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Maxwell Lee Jackson Sept. 17, 1998 Physician 10:00 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 923 Morris Ave. Lutherville Baltimore Co. If Under 1 Year If Under 24 Hrs Hours Min 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** Deys Months 15M 20 F Director 213-30-9344 65 June 30,1933 Maryland Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Co. Lutherville 1 ☐ Yes 2 ☑ No rms 23a or 28a-f s Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or frama 23a or 923 Morris Ave. 21093 United States 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 Yes 2 No altimore, Maryland 21215-0020 Specify: Specify: White À 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Transportation 12 n/a Truck Driver Green Container pernit. Pages 1 and 2 should be filled Department of Health and Mental Hygis Important: If Isan 27 is marked other any Injury or other traumadic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Suter Grant Jackson Gertrude Maxwell 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Brenda L. Hough (Daughter) 4052 Trebor Court Jarrettsville, Md. 21084 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ØCremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 9/18/98 Towson, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 e, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, List only one cause on math line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical AderoCAACINONA Examine Due to (or es a consequence ol): buriai-transit that the death certificate be assecuted Sequentially list conditions, if any, leading to im/nediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence ol): Pud physician s s the burlai-Box 68760. Physician/Medical Due to (or es a consequence of) ... Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t CARCICAMA 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Mouth Completed peen has 1 Yes 1 ☐ Yes 2 ☐ No certificate 25. Wes case referred to medical examiner? 8 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA This 27. Manner of Deat 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? A pr Attachding I 1 Naturat
2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, lactory, office building, etc. (Specify) 4 Homicide Hospital 24 hours Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

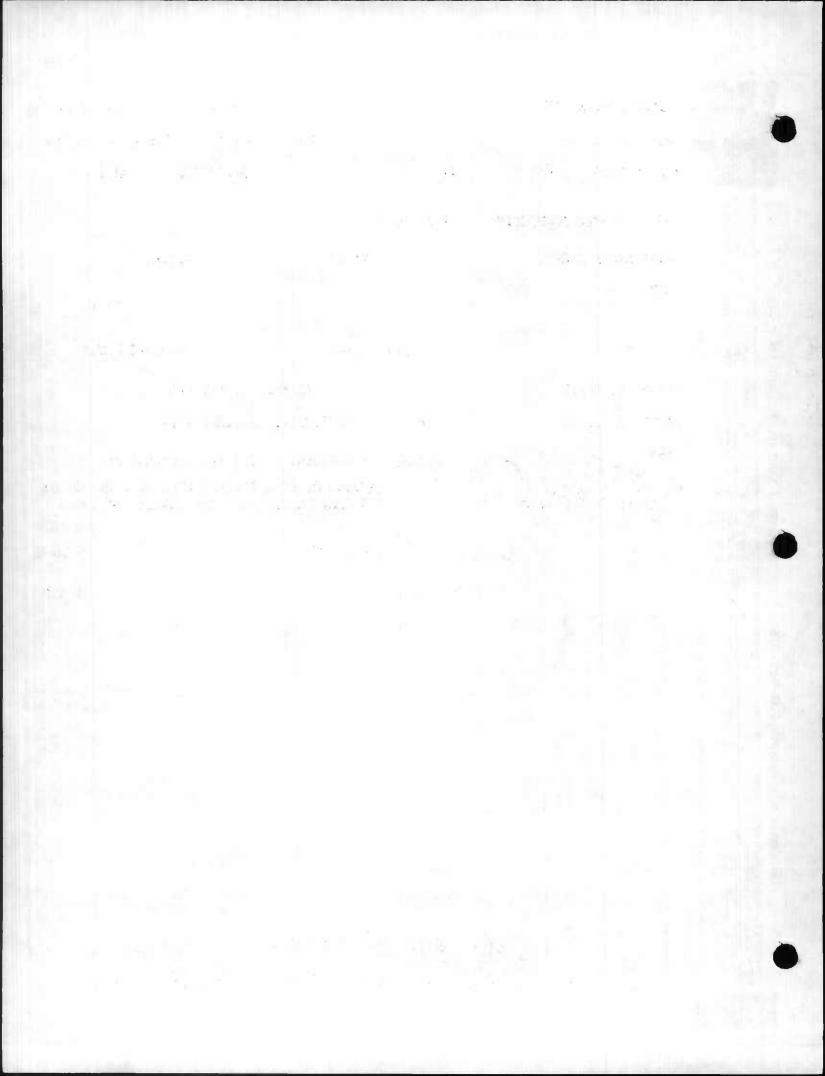
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only mination and/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) within 2 To the 29b. Signature and title-obcertifier 29c. License number D2533 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , M.D. 302 GREEN SPRING STATION 2360 W. JOPPA PD. LUTHERVILLEND. FISHER 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State SEP 2 1 1998 Registrar

DHMH 16 Rev 6/95



# Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

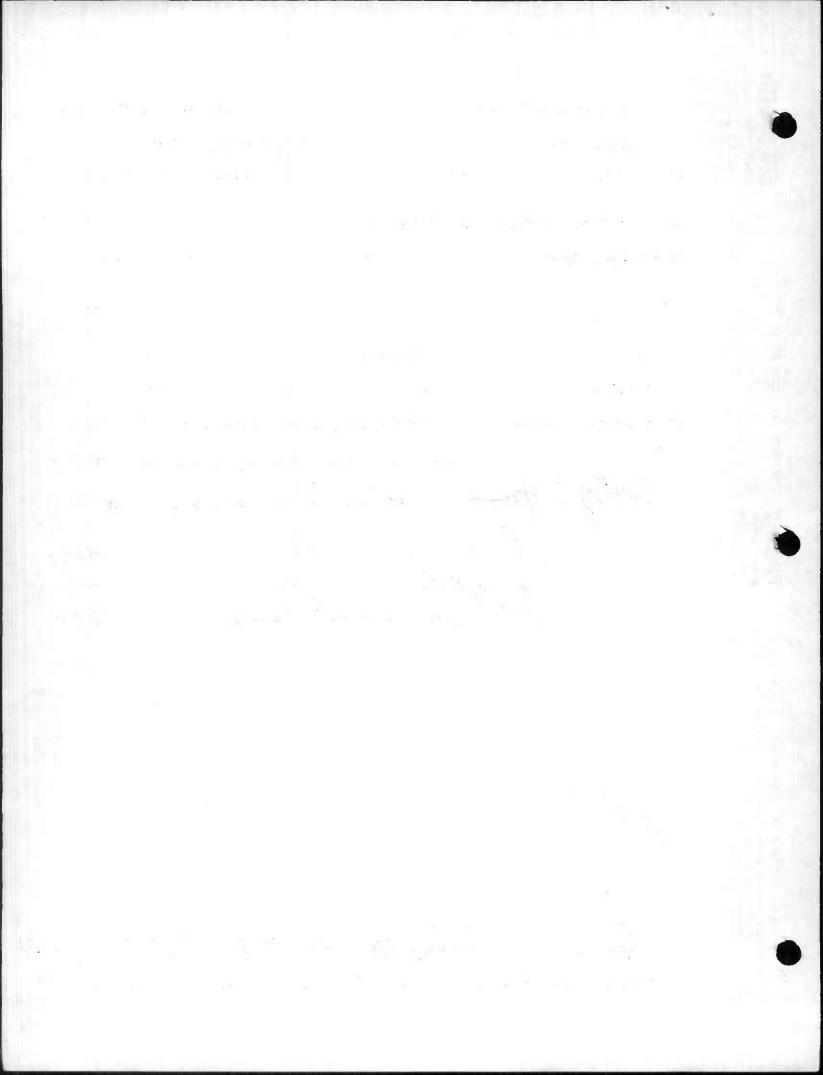
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Physician		Decedent's Name							2. Data of D Month	eath Day	Yaar		
/Medical		JOHN PA	AUL KRAF	T					Septem	ber is			
Examiner	48	Facility Name (II		va street and number				01	or Location of Dea		ounty of Dea		
		North			oitel		K Hadad Wass	6len G	surnie			Arundel	
uneral irector		Social Sacurity N 217-22-1	836	Sax 7.	Age (In yrs. las	Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of B (Month, D) 5/25/1	926	9. Bi	rthplace (State or Fo country) RY LAND	
<b>*</b>	-	sual Residence of Da. State	Decedent 10b. County		10c. City.	Town or Loca	ation					10d. inside City Li	
28a-f ahow nout ad at	5	MD	BALTIMO	DE CITU	RAI	LTIMOR	r					XXYes 2	
28a-f aho nout ad a rector	10	De. Street and Nun		KL CITY	DAI	LILMUK	10f, Zip Code			10a. Citiza	an of What C	Country?	
offer death with the Merita reference 23a or 28a-f and the must be notified Funeral Director			XTH STRE	CT			21225						
Tera	1:	I. Marital Status	AIII SIKL	12. Was Deceda				Hispanic Origin	? (Specify Yas or Nuerto Rican, etc.)	No- 14. Race - American indian,			
by	3	XXXever Marri	ed 2 Married	Armed Force	s? □ No				uerto Rican, etc.)		Black, Whi	ite, etc.	
	2	3 Widowed	4 Divorced	If Yes, Give Yaar or Date	If Yes, Give 1 ☐ Yes 2 🛣 1 ☐ Yes 2 🛣					S	Specify: WHITE		
d other than "natural", avent, the Medical Exa avent, the Medical Exa Be Completed by		/Snec	15. Decedent's E	ducation		16a. Deceda	ia. Decedant's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)			16b. Kind	of Business	Business/Industry	
nen "		Elementary/Seco		College (1-4d	or 5+)	iife. DO NOT use retired) SUPERVISOR					THLEHEM STEEL		
CO	5	12				Sur	EKV13UK					SIEEL	
	17	7. Father's Name (		1)					Name (First, Middl		umame)		
To To	-	THOMAS E							LL V. LAT				
rauer.		9a, Informant's Na		(Type, Print)					r Rural Routa Num			Zip Code)	
If Item 27 I		PATRICIA			20h Pla		ition (Name of	KCHILL,	MARYLAND			r Town, State	
	20	a. Mathod of Disp XXX urial 2 [		Removal from Sta	cen	netery, crema	atory or other pla						
Important: If any injury o			5 Other (Speci		MARI	/LAND	VETERAN	CEM.	9/18/98	CROW	nsvill	E, MD	
physiciametrals to the buriek ransit edical Examiner	Sit	equentially list cor any, leading to im ausa. Entar Unda ause (Disease or	nditions, mediate rlylng	b. Mr	eumm	as a conseque						1 Day	
5 5		ause (Disease or at initiated events ssulting in death) L		d	Dua to (or a	s a consequ	ance of):						
for us													
d by the letached		art II, Other signifi	cant conditions	contributing to death	n but not resulti	ilting In the underlying cause given In Part I.  23b. Did tobacco use c  1 Yes 2 No						ontribute to the cause of and 3 Probably 4 Unkn	
a b d be				43	M.				24a. Wa	s an autops	y 24b	Wera autopsy findi avallable prior to	
s been 2 shoul pleter	-								_			completion of caus of death?	
ege 2									10	Yes 2	No	1 Yes 2 No	
rector, per	2	5. Was case rater	red to medical		/			26. Placa of	Daath (Check only	one)			
his certificate he director, pege To Be Com		examinar?	No	Hospital:	atient 2 E	R/Outpatient	3 DOA O	her:	ng Home 5□Re		□Other (Sp	pecify)	
6 =	27	7. Manner of Death		28a. Date of I (Month,		8b. Time of	28c. Inju		28d. Describe				
ctor: After y the fune fication		2 ☐ Accident	Investigation	n				Yes 2□No					
al Director: After the director of the funeral Certification:		3 ☐ Sulcida 4 ☐ Homicida	6 Could not l	200. Placa of	injury - At hom etc. (Specify)	e, farm, stre	et, factory, office			(Street and own, Stata)	Number or F	Rural Routa Number	
C ed C			/		, , , , , , , , , , , , , , , , , , , ,								
To the Funeral Director: A completely filled in by the fi	2	9a. Certifier (Check only		hysician: To the be minar: On the basis	s of examinatio								
Med		one)	title of contilion	and mannar	stated.		20o Licen	se number		20d Date	eigned (Mo	nth, Day, Year)	
28	2	9b. Signature and	title of cartifler	0.1	10111	don 1	4 /1 /	-	. /				
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Registrar		OL.	100	/	-	1	Laborated S						



State of Maryland / Department of Health and Mental Hygiene 99 22701

Physicia				(	Certificate	oi Dealii	1	Reg. No.			
	n	Decedent's Name (First, Middle, La.	st)				2. Date of De Month		3. Time of D		
/Medica	al :	Jennie Eliza						ber 18,19			
Examine	er	4a. Facility Name (If not institution, give	and the same of th				, or Location of Deeth				
		7404 Potomac Cour			Milada		rrollton		Georges		
Funeral Pirector		5. Social Security Number 6. S 217-22-6989  Usual Residence of Decedent	□M 2VDF	(In yrs. last birth	nday) If Under Months		Hrs. 8. Date of Bir (Month, Da August	y. Year) 9, 1901	9. Birthplace (State or F Country) Maryland		
Mo to		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City		
Tiest .	to	Maryland Prince G	Senraes	New Carr	collton				1 ☐ Yes 2		
7 28a	Director	10e. Street and Number	icor ges	itch out i	10f. Zip	Code		10g. Citizen of Wh	at Country?		
38.0		7404 Potomac Cour	+		207	24		United S	tatos		
Link	Funeral	11. Maritai Status	12. Wes Decedent Ev	ver in U,S.		ent of Hispanic Origin ify Cuban, Mexican, P			American Indian,		
0 🗎	by Fui	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		If Yes, speci		uerto Ricen, etc.)	Black, Specify:	k, White, etc.  White		
"natural".		15. Decedent's Ed	ducation	nn 16e Decedent's Usual O				16b. Kind of Busi			
Med	Completed	(Specify only highest gra Elementery/Secondery (0-12)	de completed) (Give kind of work life, DO NOT use			k done during most of a retired)	working				
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5 5 S	Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	Maiden Sumame)			
marked o	0	William	Hilo	debrand	orandt M			Scroggs			
and N		19a. Informant's Name/Relationship (		Hildebrandt  19b. Mailing Address (Street ar			r Rural Route Numbe	22	tate, Zip Code)		
27 is		William Ball / Ne	nhew	740	04 Potom	ac Court I	New Carrol	Iton MD			
if Itam 27 or other tr		20a. Method of Disposition	Date	20c. Location - Ci							
		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Donetion 5  Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Gardens of Faith Sept. 21, 1998 Baltimore,									
Important: I any injury o	-	21. Signature of Funeral Service Licen		Garden		Address of Facility	21, 1998	Baltimore	e, Maryland		
Important: h any injury o		LUMPIUM C	4		Leonard	J. Ruck,	Inc.				
		June 1 mg 3	Tar		5305 Ha	rford Road	d Baltimo	re, Mary	land 21214		
		23a. Part1. Enter the distance, or companies, or heart failure. List only	plications that caused the	ne deeth. Do no	ot enter the mode	of dying, such as car	diac or respiratory e	rest,	Approximete Interval Betwe		
sician	1		4	1	1				Onset end De		
edical aminer		Immediate Cause (Final disease or condition	Merms	sof 1	Greus	evites			days		
		resulting In death)	1 0	ue to for as a co	onsequence of):				1		
= .	<u> </u>		peart	farten	9 + 12	relighton			weeks		
and I-trans	Examine	Sequentially list conditions, if eny, leading to immediate	- 1000	ue to (or 45 a co	naguence of	1, 1			110		
	ו נ	if eny, leading to immediate	allers	orless	the do						
es -		Cause (Disease or injury				my dis	eage		years.		
CE -		ceuse. Enter Underlying Cause (Disease or injury that initiated events	Du	ue to (or es e co	nsequence of):	my clis	eal		years.		
CE -		Cause (Disease or injury that initiated events resulting in death) Last	Du	ue to (or es e co	nsequence of):	my clis	eal		years.		
ing physicia e es the bur	Medical	that initiated events	d.	ue to (or es e co	nsequence of):	and clip	eal		years.		
ettending physicia for use es the bur	Medical	that initiated events resulting in death) Last	d			and clip	23b Did	lobacco usa confi	Thut to the cause of		
ettending physicia for use es the bur	Medical	that initiated events	d			use given in Pert 1.		1			
by the ettending physicial tached for use es the bur	Physician/Medical	that initiated events resulting in death) Last	d			use given in Pert f.	23b. Did 1	1/			
igned by the ettending physicial be detached for use as the bur	by Physician/Medical	that initiated events resulting in death) Last	d			use given in Pert f.	1 🗆	Yes 2 No 3	sutopsy d? 24b. Were eutopsy findings eveilable prior to completion of cause		
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certificate has been signed by the ettending physicial rector, page 2 should be detached for use as the burnerior of the contraction of the contra	be completed by Physician/Medical	Part II. Other eignificant conditions co	d	not resulting in t		26. Place of	24e. Wes perfo	en sutopsy med?	Probably 4 Un  24b. Were eutopsy find eveilable prior to completion of ceu of death?  1 Yes 2 No		
his cartificate has been signed by the ettending physicial director, page 2 should be detached for use es the bur	lo be completed by Physician/Medical	Part II. Other eignificant conditions co	d	not resulting in t	the underlying ce	26. Place of	24e. Wes perfo	en sutopsy med?  //es 2 No	Probably 4 Un  24b. Were eutopsy find eveilable prior to completion of ceu of death?  1 Yes 2 No  (Specify)		
his certificate has been signed by the ettending physicia if director, page 2 should be detached for use as the but if page 2 should be detached for use as the but if Development in the page 2 should be a page 3 should be	lo be completed by Physician/Medical	Part II. Other eignificant conditions co	d	not resulting in t	the underlying ce	26. Place of  Other: 4 Nursing  No. Injury at  Work?	24e. Wes perfo	en sutopsy med?	Probably 4 Un  24b. Were eutopsy find eveilable prior to completion of ceu of death?  1 Yes 2 No  (Specify)		
or. After this certificate has been signed by the ettending physicial funeral director, paga 2 should be detached for use as the burnel of the formal director and the formal	lo be completed by Physician/Medical	Part II. Other eignificant conditions co	Hospital: 1 Inpatient 28a. Date of injury (Month, Day )	not resulting in t	the underlying ce	26. Place of  A Other: 4 Nursin  Bc. Injury at Work? 1 Yes 2 No	24e. Wes perfo	en sutopsy med?  (es 2 No dence 8 Other now injury occurred)	Probably 4 Un  24b. Were eutopsy find eveilable prior to completion of cau of death?  1 Yes 2 No  (Specify)		
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or After this certificate has been signed by the ettending physicial funeral director, paga 2 should be detached for use as the burner of the formal director and the formal d	Certification: 10 Be Completed by Physician/Medical	25. Was cese referred to medical examiner?  1	Hospital: 1 Inpatient 28a. Date of Injury (Month, Dey ) 28e. Place of Injury building, etc.	not resulting in t	patient 3 DO/me of ury Mm, street, factory, death occurred a	26. Place of  A Other: 4 Nursi  BC. Injury at Work? 1 Yes 2 No office	Death (Check only on the control of	en sutopsy med?  Yes 2 No  dence 8 Other now injury occurred.  Street and Number vn., State)	Probably 4 Un  24b. Were eutopsy find everilable prior to completion of ceu of death?  1 Yes 2 No  (Specify)  or Rural Route Number		
the After this certificate has been signed by the ettending physicial funeral director, page 2 should be detached for use as the burneling of the control of	edical Certification: 10 be Completed by Physician/Medical	25. Was cese referred to medical examiner?  1	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day') 28e. Place of Injury building, etc.	2 ER/Outp Year) 28b. Tir Inj y - At home, farm (Specify)	patient 3 DO/me of ury Mmn, street, factory, death occurred a	26. Place of  A Other: 4 Nursi  BC. Injury at Work? 1 Yes 2 No office	Death (Check only on the control of	en sutopsy med?  Yes 2 No  dence 8 Other now injury occurred.  Street and Number vn., State)	Probably 4 Un  24b. Were eutopsy find everilable prior to completion of ceu of death?  1 Yes 2 No  (Specify)  or Rural Route Number		
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he Function: After this certificate has been signed by the ettending physicial pletchy filled in by the funeral director, paga 2 should be detached for use as the burnished in the funeral director. To Be completed by Bhysicial and the function of the funeral directors and the function of the function	Medicar Certification: To be Completed by Physician/Medical	25. Was cese referred to medical examiner? 1   Yes   2   No   27. Manner of Death 1   Netural   5   Pending investigation   3   Suicide   6   Could not be determined   29a. Certifier (Check only one)   Certifying Physical	Hospital: 1 Inpatient 28a. Date of Injury (Month, Dey') 28e. Place of Injury building, etc. yelclen: To the best of eand manner state	not resulting in to 2 ER/Outp	patient 3 DO/me of uny Mmn, street, factory, death occurred a for investigetion,	26. Place of  A Other: 4 Nursing  Bc. Injury at Work? 1 Yes 2 No  office  It the time, date and plan my opinion, death of	24e. Wes performed to the securred at the time,	en sutopsy med?  es 2 No  des 2 No  des 8 Other now injury occurred.  Street and Number m, State)  cause(s) and manndate and place, and	24b. Were eutopsy find ever eutopsy find eutopsy		

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 4b. City, Town, or Location of Death 4c Country Death 5:40PM John Alexander Luetkemeyer, Sr /Medical 4a Facility Nama (If not institution, giva street and number) **Examiner** Roland Park Place Baltimore City N/A If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 5. Sociel Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Deys 88 Director 215-07-6113 Ohio Usuel Residence of Deceden the Maryland 10c. City. Town or Location 10a. State 10b. Count 10d. Inside City Limits 7 is marked other than "natural", or hems 23s or 28s-f show traumatic avant, the Medical Examiner must be notified at 1 Nes 2 No Director Md. N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 830 West 40th Street 21211 USA Funeral 12. Was Decedant Evar in U.S. Armed Forcas? 1 to Yes 2 □ No If Yes, Giva WWII Yaar or Detas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If ham 27 is marked other than "natural", or her any Injury or other traumatic avenue. Bleck, White, etc. 1 ☐ Never Merried 2 ☑ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Banker Banking +4 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Nema (First, Middla, Last) Be Gustav Luetkemeyer Julia Lueke 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 17 W. Pennsylvania Ave. Towson, MD. 21204 Mr. Jack Luetkemever/Son 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 A Cramation 3 ☐ Removel from State 4 □ Donetion 5 □ Other (Specify) Hilltop Service Co. 9-19-98 Towson, MD. 21. Signature of Funeral Service Is 22. Name end Addrass of Fecility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting In death) MYOCARDIAL Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760. Physician/Medical Due to (or as a consequence of). 950 P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Wes case reterred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Noting Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) Medical Certification: 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation Attending 1 DMaturel 1 Yes 2 No fine death. 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, term, street, factory, office building, etc. (Specify) 4 Homicide 1 Contifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and tyle of certifier 30. Name and address of person who completed pause of death (Item 23a) (Type, Print)

State Registrar

31. Dete filed (Month, Dey, Year) SEP 2 1 1998

10755 Falls Rd.

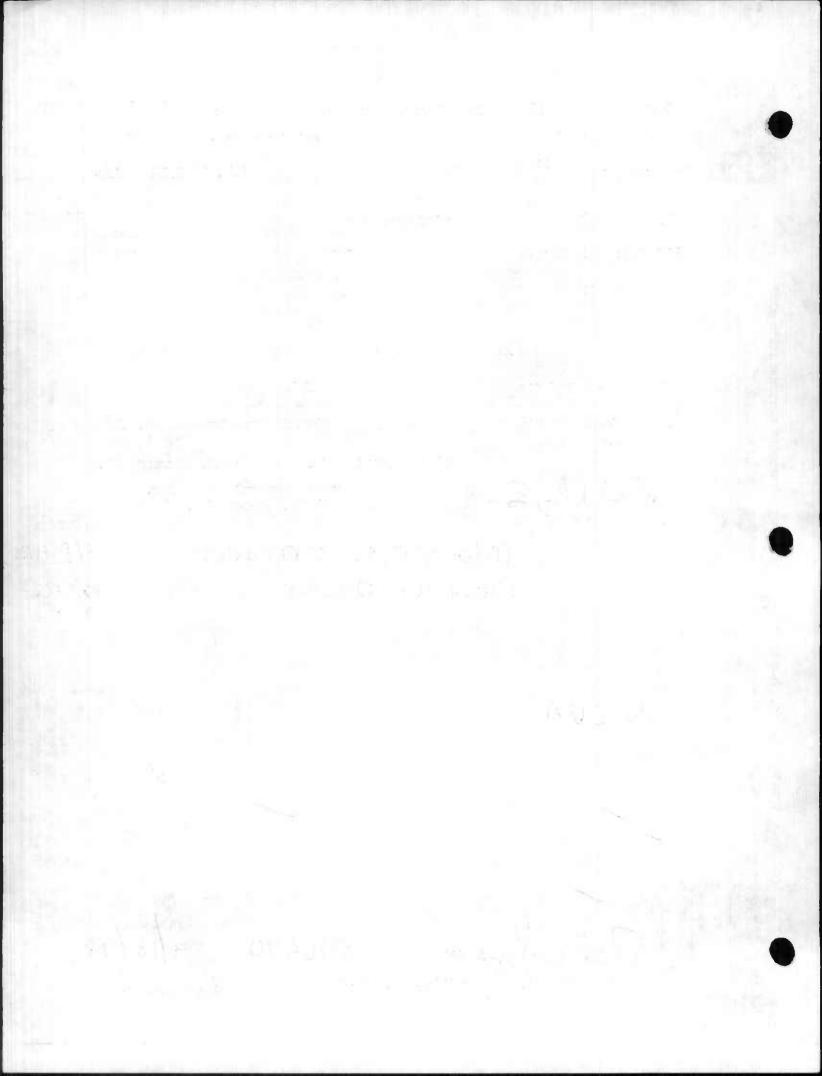
32. Registrer's Signeture

G. Sparker

Lutherville, MD. 21093

G. SAPIR

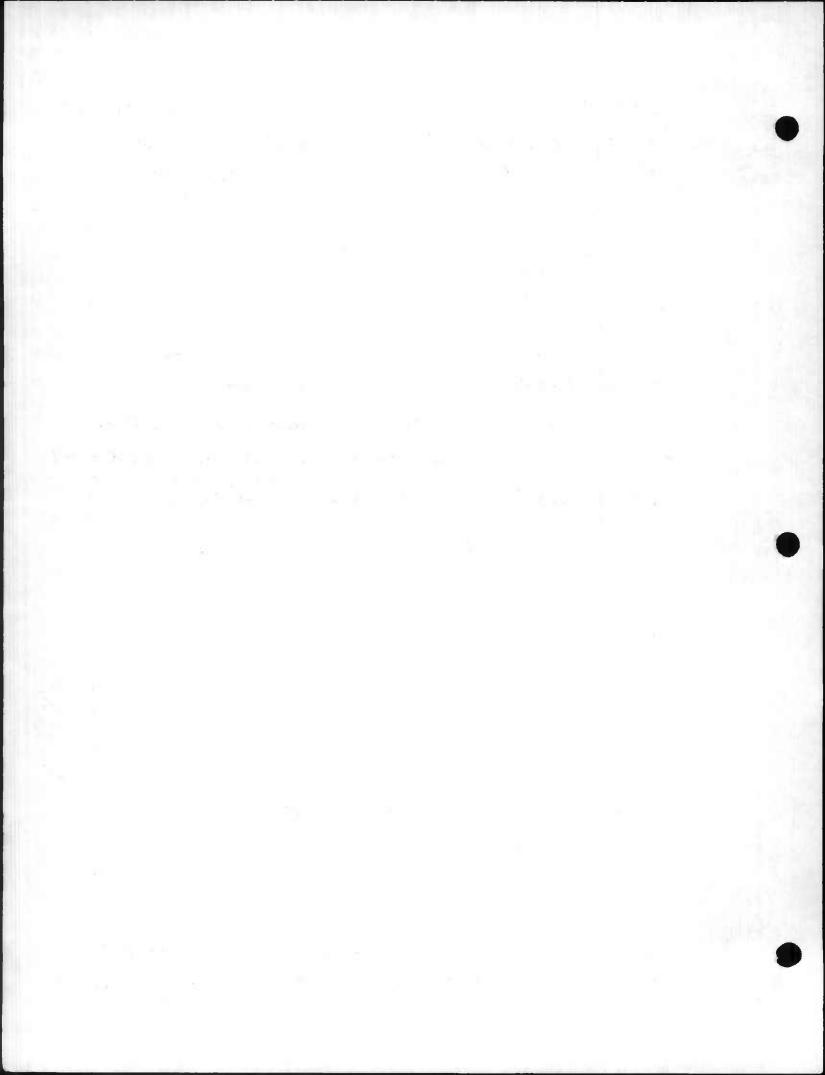
DANL



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedents Neme (First, Middle, Last) 2. Dete of Deeth 54 m **Physician** Month /Medical me iff not institution-give stre 4b. City, Town, or Location of Deeth and number 4c. County of Death **Examiner** 8718 Parkyille If Undar 24 Hrs. EN Baltimore 7. Aga (In yrs. last birthday) 68 Yrs. if Under 1 Yaar 5. Sociel Security Numbe 218–26–4956 Birthpleca (Stete or Foreign Country) **Funeral** Months Deys Hours 1 M 2 SOK Director Oct. 20, 1929 Usuei Residence of Decedent the Marylend 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryler Deportment of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any litury or other traumatic event, if it was 10 and other traumatic event. Md. 1 Yes 2 No Director Harford Edgewood 10f. Zip Code 10g. Citizen of Whet Country? 319 Redbud Road 21040 USA Funeral Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 12. Wes Decedant Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3√Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Clerk Div. of Vital Records 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Delano Muir Washington, Sr. Beulah Jensen P 19a. Informent's Name/Relationship (Type, Print) Daughter 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) DeLane Morris 4437 Shamrock Avenue Baltimore, Md. 21206 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 1 Buriai 2 Cremation 3 Removel from Steta 4 Donetion 5 Other (Specify) Sept. 17 Westminster, Garden of Eternal Hope Md. 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signeture of Funerel Service Licenses alers 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part1. Enter the disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Onset end Death **Physician** /Medical Immediete Ceuse (Final disease or condition resulting In death) Examiner Examiner Derma physician end the bunal-transit Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760. Physician/Medical Dua to (or as a consequence of): 80 ettending properties of P.O. ate hes been signed by the e page 2 should be detached t Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Wonknown Records, by 24b. Were eutopsy findings aveilable prior to completion of ceuse of deeth? Completed 24e. Was en eutopsy performed? certificate hes 1 ☐ Yes 2 ☑ No 1 Yes 2 1 M Division of Vital Attending Physician: 25. Wes cese referred to medicel Be 26. Plece of Deeth (Check only one) exeminer' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA er death. funeral 27. Menger of Deeth 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not ba 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) after Direct 4 Homloide Medical 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. Licansa numbar 29d. Deta signed (Month, Day, Year) MD 30 Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)

Suresh Shortelyg MD 3007 0 31. Date filed (Month, Day, Yeer) Registrer's Signeture State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 17 17 1998 11.50 PM Lofton Thomas 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Name (If not institution, give street and number) Anne Arundes Arundel North If Under 1 Year 6. Sex 1 M 2 □ F 7. Age (in yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number Days Yrs. March 17,1925 Michigan 386-14-6259 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No Maricopa Sun City West Arizona 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code USA 17207 N. 130 Drive 85375 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indien, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Loan Officer Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) C. Lofton Maud Greelv Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17207 N. 130 Drive, Sun City West, AZ 85375 Lofton - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Sun City West, AZ 4 □ Donation 5 □ Other (Specify) Camino Del Sol 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part I. Enter the disease, or complications that caused the double shock, or heart failure. List only one cause on each line. o not enter the mode of dylng, such as cardiac or respiratory errest, Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) MYOCARDIAL INFARCTION WEEK 3 DAYS ANOXIC ENCEPHALOPATHY Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 1 Yes 20 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2IP No Hospital: 1 Dinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural

Physician /Medicai Examiner and

Department of Health mportant: If item 27

ò

**Physician** 

/Medical

**Examiner** 

Director

Funeral

3

Completed

**Funeral** 

Director

or 28a-f

238

the Medical Examiner must be notified

Examiner

Physician/Medicai

the 80 use i certificate has After this

by Completed Be Certification: To

Medical

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

death certificate be exec Box 68760. Division of Vital Records, or Attending Parties after death. To the Hospital o within 24 hours af To the Funeral Di

Registrar

29b. Signature and title of certifie

6 Could not be determined

MEDICAL DOCTOR

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number D 0052277

1 Yes 2 No

29d. Date signed (Month, Day, Year) SEPTEMBER 17TH 1998

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

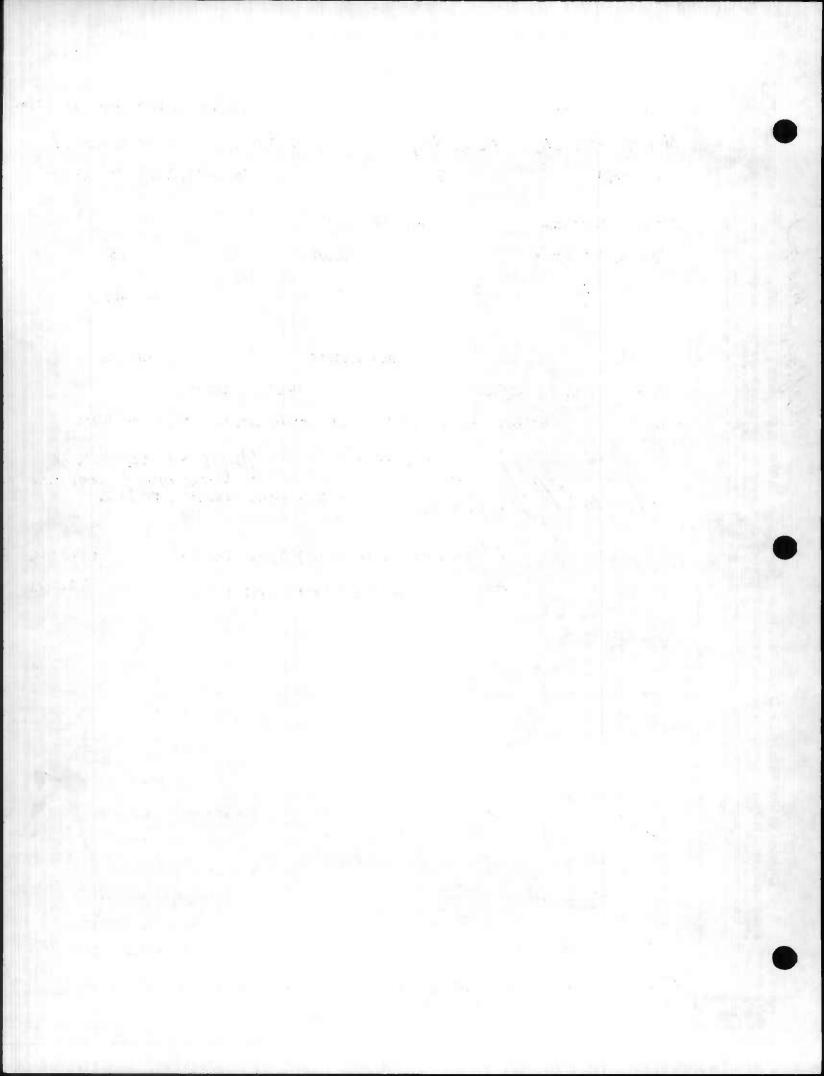
ATTIOGRE NORTH ARUNDEL HOSPITAL, MARYLAND TRANCIS KWASHIE 31. Date filed (Month, Day, Yeer)

SEP 2 1 1998



1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(a) and manner es steted.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.



98-5496-005

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	JOHN LACKL 1	TEM	S: #23 PART I, 27,							Health and Machine Property of the Machine Property of	Mental Hy	rgiene 9	8 2	28705	
			1. Decedent's Neme (First, Midd							FILE L	2. Dete of De			3. Time of Death	
	Physici	i	John Anthony	Lack1							SEPTEM	BER 18,1	1998	3:40P.M.	
	/Medi Examir		4a Facility Neme (If not Institution			nber)				4b. City, Town, or L	ocation of Deet	th 4c. County	4c. County of Deeth		
4	Lxamii		ST.JOSEPH HOSPI	TAL						TOWSON		BALT	IMOR	E	
	Funeral Director		5. Social Security Number	6. Sex	/ 2□ F	7. Age (In yrs. lest birthdey)   If Under 1 Ye   Months   Der					8. Date of Bir (Month, De Januar)	Birth 9. Birthplece (State or For Country)  Y 20, 1998 Maryland			
	P		Usual Residence of Decedent												
	and 21215-0020 be filed within 72 hours after death with the Maryland hall Hygiena. vd other than "natural", or Nems 23s or 28s-f show event, the Medical Examiner must be notified at the Completed by Funeral Director	_	10e. State 10b. Count			100.		or Location					0d. inside City Limits 1 ☐ Yes 2 No		
		acto		Baltin	nore		Par	kvill							
Olre	급	10e. Street end Number					10	M. Zip Code			10g. Citizen of V				
	23	eral	2335 Foster A			deet Francis	11.0	12 14/20 /	2123		anaite Van ar Ne			tates can Indian,	
	er de	Fun	11. Maritel Stelus		Armed For		0,5.	if Yes	, specify Cul	Hispenic Origin? (Spoan, Mexican, Puert	Rican, etc.)	Blee	ck, White,		
Maryland 21215-0020	iral", or	by	1X Never Married 2 Ma 3 Widowed 4 Divorce		1 ☐ Yes If Yes, Giv Yeer or De	9		1 ☐ Yes 2 【X No		Specify:		Specify: White			
5-(	72 h	ete	15. Decede (Specify only highe	nt's Educa est grede d	tion completed)		16e.	Decedent's (Give kind	Usuei Occu of work done	ipation a during most of wor ad)	king	16b. Kind of B	usiness/In	dustry	
12	within ena.	Completed	Elementery/Secondary (0-12)		College (1	4or 5+)				90)		Not Sol	f Su	nnorting	
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an	od be do	Be o								Melani					
Z	should be nd Mentel marked c	70	Larry Lack1,	Print1		10h	Meiling Ad	Idraes /Strae				State 7ir	ete, Zip Code)		
Ma	Pages 1 er nent of Hea int: If Hem?		19a. Informent's Neme/Reletionship (Type, Print)  John A. Beard / Grandfather  19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zig  2335 Foster Avenue Baltimore, MD 21234											, 0000)	
e,			20a. Method of Disposition  20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca)  20c. Location - City or										own, Stete		
o D			1 X Burial 2 ☐ Cremetion		novel from S						122/00				
Itin			4 Donetion 5 Other (		,		orela			1 Park 9	/22/98	Baltimo	ore,	Maryland	
Ba	Depentit. Depentit Importa		21. Signature of Pullera Service	C	+/11.					. Ruck, I	nc. Fun	eral Hon	ne		
-			summy any	7	11w			530	5 Harf	ord Road	Baltim	ore, MD	2121		
J.			23a. Part1. Enter the disease, o shock, or heart failure. Lis	t only one	cause on ea	ach line.	atn. Do n	ot enter the	mode of dy	ing, such es cardiac	or respiretory e	errest,	1	Approximete Intervel Between Onset and Deeth	
	Physician /Medical	Þ	Immediete Ceuse (Finel				SHEED	CATION	1					0,100, 0.10 200.11	
1	Examiner		disease or condition resulting in deeth)	Θ			SUFF	JCA1 LUN							
п		-				Due to	(or es e c	onsequenc	e of):						
	ted nsit	Examiner		b											
	death cartificate be executed e attanding physician end of for use as the buriel-trensit	xar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		Due to (or es e consequence of):								i		
8760,	be e siciar	Te l	cause. Enter Underlying Cause (Diseese or Injury that initieted events	C	C										
687	ifficete g phy as the	edical	resulting in deeth) Lest		Due to (or es e consequence of):										
Box	aath cartif attanding for use a	3		d											
ă	atta d for	Physician/M	Pert if. Other significent conditi	ana contri	huting to do	ath hut not r	naultina in	the underly	vino onuco o	iven in Bort I	23h Did	I tohecco use co	otribute t	o the cause of death?	
0	the the	hys	reit ii. Other significent condit	One Contri	buting to de	atti but not n	sauting in	tile diloen	ying cause g	NACT III P GIT I.		Yes 2 No			
D.		by P													
Records,	requires										24e. Wes	s en eutopsy	24b. W	ere eutopsy findings reliable prior to	
00		Set									pen	formed?	CC	impletion of cause deeth?	
Re	0 - 0	Completed									1 127	Yes 2□No	11	Yes 2 No	
Vital		0	25. Wes case referred to medical	al						26. Plece of Dea			1	3 100 22 100	
>	Physician: this certific	0 8	exeminer?		spital:	patient 2	☑ ER/Out	netient 3	DOA O	ther		sidence 6 Oth	er (Speci	fv)	
of	F F is	-	27. Manner of Deeth		_	f Injury h, Dey Year)	-	ime of				how injury occur		AD AND TORSO	
lon	5 . 5 5	tio	1 ☐ Neturel 5 ☐ Pendi 2 🖾 Accident invest			n, Dey Year) 9 <b>-1</b> 8-98		njury ND:3:10 <sup>4</sup>		28c. Injury at Work? 1 ☐ Yes 2 ☑ No		ED IN BLAN		110 1110 10100	
Division	or Attending after death. Director: Afte d in by the fune	Iffice	3 ☐ Sulcide 6 ☐ Could	not be	28e. Place	of Injury - At						(Street end Num!			
Ö		Certification:	4 Homlcide		buildin	FOUND	AT HOM	1E	actory, office		City or To	own, Stete) 23	35 F0S	STER AVE.	
	To the Hospital o within 24 hours af To the Funeral Di completaly filled in	edicai C				sis of exemi				time, dete end pleca opinion, deeth occu					
	To the Howithin 24 h To the Fur	Me	29b. Signature and title of cartifi	er		11	1		29c. Licer	nse number		29d. Date signe	d (Month,	Dey, Year)	

State Registrar 31. Dete filed (Month, Day, Yellr)

SEP 2 1 1998

Yestaner
32. Registrer's Signeture

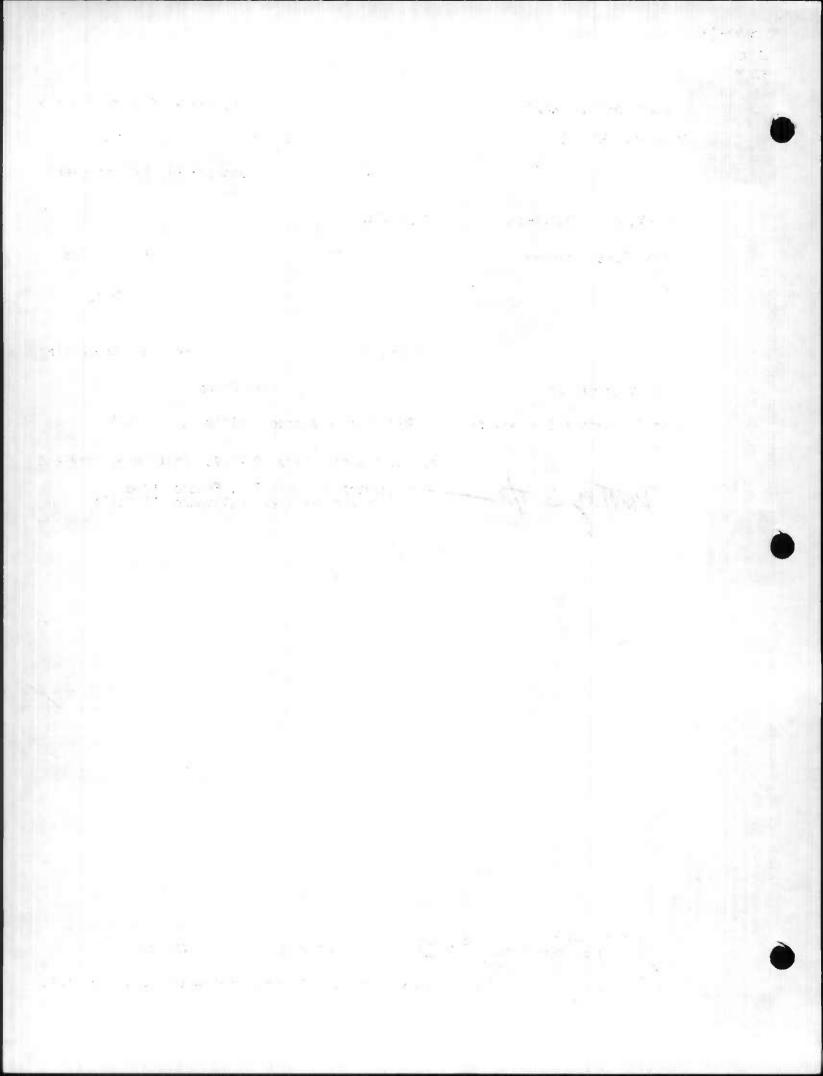
eddress of person who completed a use of death (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

SEPTEMBER 19,1998

O.C.M.E.

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey Yeer September 18, 1998 **Physician** 12:45 p.m Luke Carl Little III /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Deeth **Examiner** Carroll 3292 Charmil Drive Manchester 8. Dete of Birth
Jan 1947 9. Birthplaca (State or Foreign Country) Maryland 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 100 M 2□ F Months Deys Hours Min Director with the Meryland 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits Nam 27 is marked other than "natural", or items 23a or 28a-1 show other treumstic event, the Medical Examiner must be notified at Yes 2 No Carroll Manchester Maryland Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21102 3292 Charmil Dr. permit. Peges 1 and 2 should be filed within 72 hours efter death Department of Health and Mentel Hygiene. If flem 27 is marked other than "natural", or items 23. Funeral 12. Was Decedent Ever in U,S. Amed Forces? 1 Mayes 2 □ No If Yas, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indien Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Dacedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Farmington Freight Elamantary/Secondary (0-12) College (1-4or 5+) Truck Driver 12 17 Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha Scott Luke Carl Little Jr. 19b. Mailing Addrass (Straat end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 3292 Charmil Drive, Manchester, Md. 21102 Sharon Little 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetary, cremetory or other plece) Date 20c. Location - City or Town, State any injury or conce. 1 Burial 2 □ Cremation 3 □ Removel from Stete New Lutheran Cem. Sept. 22, 1998 Manchester, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fund Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester, Md. 21102 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or raspiratory errest, shock, or heart failure. List only ona causa on each lina. Approximate Interval Between Onset and Deeth **Physician** /lviedical Immediate Cause (Finel 10n-5houl el Cars diseese or condition resulting in death) Examiner Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initieted events resulting in death) Last Dua to (or es a consequence of): Physician/Medical Due to (or es a consequence of): 980 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed peen hes 2 No Be 26. Place of Daath (Check only ona)

Division of Vital Records, P.O. Box 68760, certificate

25. Was casa raferrad to medical examiner? 1 ☐ Yes 2 No 27. Manner of Daeth 1 Natural 2 Accident 3 ☐ Suicide 4 Homicida

29e. Certifier

(Check only one)

29b. Signeture, end title of certifier

2

Certification:

Medical

Hospital or Attanding Physician: funeral director, this After efter death. 24 hours e To the I within 2

Manshel 31. Date filed (Month, Day, Year)

30. Name end address of person who complated cause of death (Item 23a) (Type, Print) Levine

4000 Old Court Rd.

28c. Injury et Work?

1 ☐ Yes

29c. License number

Other: 4 Nursing Home

2 No

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daeth occurred at the time, dete end place, and due to the cause(s) end mannar stated. 29d. Date signed (Month, Day, Year)

5 Residence 6 □Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

State Registrar

5 Pending

Investigation

6 Could not be determined

32. Registrar's Signeture

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Pieca of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28e. Data of Injury (Month, Dey Year)

**DHMH 16 Rev 6/95** 

List Cur. r 19 -- -the Street Park ATT THE TANK OF THE · + · · o. · fire and the second . KI Chitalli Care . . . The Road Medical Street . To office from the Sont Devel Dally, Mc. Charlett, 18. 1970 . H., rever, 5.55 MM A., 50., 190 A., 190 A., 190 A. TEC LEGIL -. Sicurity E. 110TH

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death Month September 18,1998 10:18A.H Marie Elizabeth McBride 4b. City. Town, or Location of Death 4c. County of Death 4e Fecility Nama (If not institution, giva street and number) Franklin Square Hospital Bal Kosedale timore Center If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 06-22-1930 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foreign 1□ M 2 F Months Days Hours Min Maryland 68 218-26-2906 Usuat Rasidance of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No Maryland Baltimore Overlea 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number 21236 U.S.A. 108 Sipple Ave. 12. Wes Decedent Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amaricen Indian. 11. Maritel Stetus Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Dates: 1 Naver Married 2 Married 1 ☐ Yas 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home N/A Homemaker 12 Years 17. Fether's Name (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) Pfister Margaret Conrad Backert 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel J. McBride, Sr. (husband) 108 Sipple Ave. Baltimore, Maryland 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City 21236 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Removal from State 4 Donation 5 XOthar (Specify) Entomb. 9-21-98 Baltimore, Maryland Moreland Memorial Park 22. Nama and Addrass of Facility Leonard J. Ruck, Inc. 21214 5305 Harford Road Baltimore, Maryland J. Wayne Osterling e, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, List only one cause on each line. Approximeta Intarval Between Onset and Death Immediata Causa (Final diseesa or condition rasulting in daath) 14-05 ASTYMA Due to (or as a consequence of) Sequentially list conditions, if any, laading to immadiata causa. Enter Undarlying Causa (Diseasa or Injury that initiated events resulting in death) Last Dua to (or as a consequence of) Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings evallable prior to 24a. Was an autopsy performed? completion of cause of daeth? 2 No 25. Was cesa referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 20-No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Dascribe how injury occurred + Natural 5 Panding invastigation 1 | Yes 2 | No 2 ☐ Accident 6 Could not be detarmined 3 ☐ Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straal, factory, office building, etc. (Specify) 4 ☐ Homicide

physician and the bunal-transit The law requires that the death certificate be executed Records, P.O. Box 68760, signed by the attending p been signature has paga certificata Division of Vital Physician: this Attanding 24 rought or To the H

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

Be

2

Examiner

Physician/Medical

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Completed

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10

29a. Cartifiar (Check only one)

29b. Signature and titla of certifie

**Funeral** 

Director

r is marked other than "natural", or items 23a or 28a-f show traumstic event, the Medical Exploner must be notified at

2 should be filed within 72 hours after and Mental Hygiena.

Pages 1 and 2 should be

item 27 i

Department of important: if it any injury or c

Physician

/Medical

Examiner

of Haalth

the Maryland

with 1

death v

CBCIde, Maryland 21215-0020

Certification:

State Registrar

29c. Licanse number

29d. Data signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Itam 33a) (Type, Print).

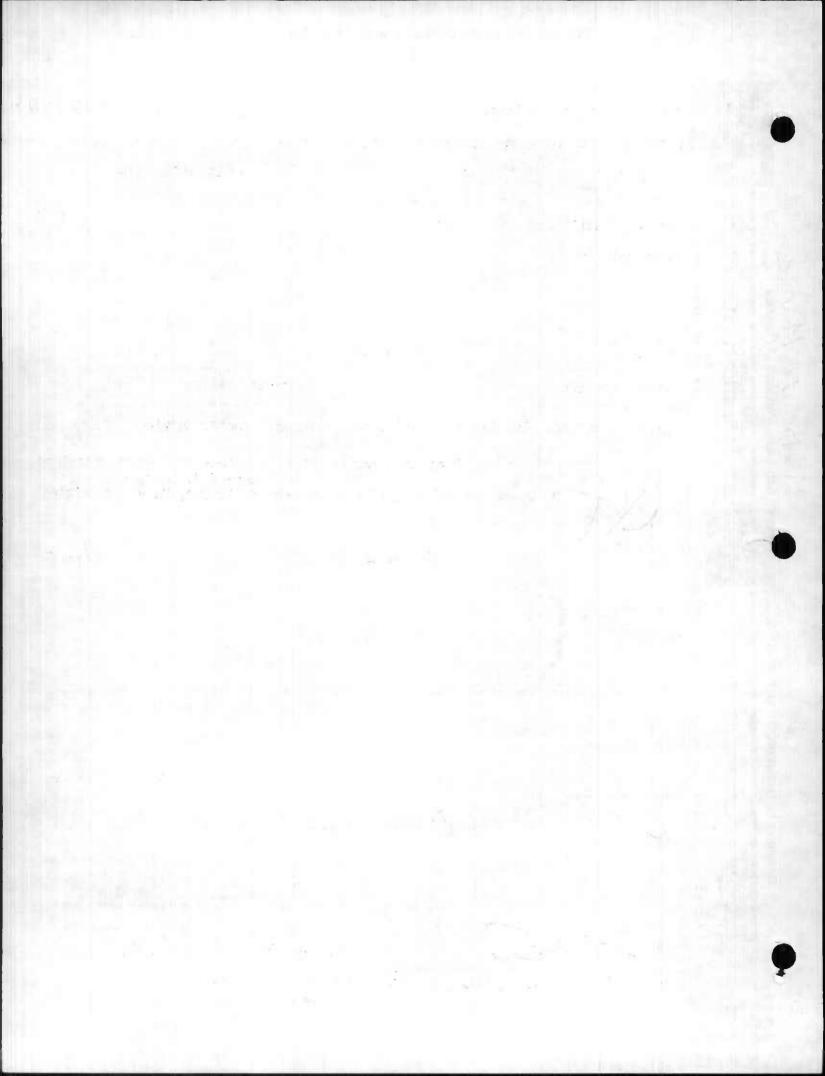
Cong Low 7672 Delay 40 19 Harre-MD 21234

Belgin Occure Low 7672

32. Ragistrar's Signature SEP 2 1 1998

Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.



State of Maryland / Department of Health and Mental Hygiene

		Ce	rtificate	of L	Death	R	leg. No.	C .	0700			
						2. Date of Dee Month	th Dey	Yeer	3. Time of Deeth			
				-	h Chu Taum au				1212PM			
and the second second				4	b. City, Town, or	Location of Death	4c. County	or Death				
			1 44 4 4 4 4				n/a	0 Ridhal	one /State or Foreign			
15 M 2□ F		Yrs.				(Month, Dey	, Year)	Birthplece (Stete or Foreign Country)				
						June 2	1, 1978	Md.				
								10	d. Inside City Limits			
n/a	Ba	ltimor	re						1 X es 2 □ No			
			10f. Zip C	Code		1	10g. Citizen of V	Whet Count	ry?			
Street			212	202			USA					
12. Was Deced	2. Was Decedent Ever in U.S. 13. Was Deceder				ispanic Origin? (S	Specify Yes or No-						
						to Hican, etc.)	Blac					
If Yes, Give	les:	1 Li Yes 2/2X			Specify:		Specify	BL	Black			
		16a. Dece	dent's Usual	Occupa	ation	odela a	16b. Kind of Bu	usiness/Ind	ustry			
	4or 5+)	life.	DO NOT use	retired	) )	rking						
		n/a					n/a					
	18. Mother's Name (First, Middle, Maiden Surne							eme)				
gue					renny S	COLL						
ionship (Type, Print) MC	ther	19b. Maili 2229	ing Address ( Eutaw	Street e	end Number or R ace Bal	ural Route Numbe timore, N	r, City or Town, Ad. 212	Stete, Zip 17	Code)			
	20b. P	lace of Disp	osition (Neme	e of		Date	20c. Location -	City or To	wn, State			
	tate			-		Sent 17	Baltim	ore.	Бм			
Water	)				14			-				
o, or complications that ca List only one cause on ea	used the death ch line.	h. Do not en	nter the mode	of dyln	g, such es cerdie	c or respiretory en	rest,		Approximete Intervel Between Onset and Death			
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a												
	Due to (o	r es e c <b>a</b> nse	equence of):									
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Mal		Maria de la compansión de			and David	005 DI 11	-h		the enues of deaths			
unions contributing to dea	un but not resi	uiting in the t	underlying ce	use giv	en in Part I.		1.0		ably 4 Unknow			
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dical					26 Place of De	N						
Hospital:	enationt o	ED/Outpot:	ant all 004	Oth				or (Snacik	ATATI, CELI			
	Injury	28b. Time o		_					,JIII CHIL			
nding (Month	(Sy Year)	Injury	M			Suhir	t 5/266	edin	iail			
uld not be 28e. Place of	of Injury - At he	ome, ferm, si			/\	28f. Location (S	Street end Numl	ber or Rura	I Route Number,			
buildin	g, etc. (Specif	Y) A	7			City or Tou	m. State)	en 57	21212			
itving Physicien: To the h	est of my kno	wiedge, deal	th occurred a	t the tin	ne, date and place	1170	euse(s) end m	enner es si	eted.			
cal Examiner: On the bas	sis of examine	tion end/or Ir	nvestigetion,	in my o	pinion, deeth occ	urred et the time,	date end place,	end due to	the ceuse(s)			
			29c.	License	e number		29d. Date signe	ed (Month,	Dey, Year)			
	R STREET-BAL  6. Sex  12. Was Decer  Married   12. Was Decer  Armed Ford  1   Yes, Give  Year or Da  Ident's Education  ghest grade completed)  12)   College (1-  Ide, Lest)  Gue  Identify  Identi	Montague  ution, give street end number)  R STREET-BALTIMORE  6. Sex  12. Was Decedent Ever in U. Armed Forces? 1	Montague  ution, give street end number)  R STREET—BALTIMORE CITY  6. Sex  Due to (or es a consection of the death of the	Montague  Witon, give street end number)  R STREET -BALTIMORE CITY JAIL  6. Sex  7. Age (n yrs. last birthdey)  10c. City. Town or Location  Baltimore  10d. Zip C  212  Married  112. Was Decedent Ever in U.S. Armed Forces?  Armed Forces?  Married  112 Yes 28 28 No 113 Was Decedent U.S. Armed Forces?  Married  120 College (1-4or 5+)  118a. Decedents Usual (Chire kind of work life. Do NOT use (Chire kin	Montague  ution, give street end number)  R STREET-BALTIMORE CITY JAIL  6. Sex  9. 7. Age (in yrs. last birthdey)  10c. City, Town or Location  Baltimore  10f. Zip Code  21202  Married  11. Was Decedent Ever in U.S. Armed Forces?  Married  12. Was Decedent Ever in U.S. Armed Forces?  Married  13. Was Decedent of H  14 Yes, specify Cube  15 Yes, Give  16 Armed Forces?  Married  17 Yes 25 No  18 Decedents Usual Occup  (Give kind of work done to life. Do NOT use retired  18 Decedents Usual Occup  (Give kind of work done to life. Do NOT use retired  19 Decedents Usual Occup  (Give kind of work done to life. Do NOT use retired  19 Decedents Usual Occup  (Give kind of work done to life. Do NOT use retired  19 Decedents Usual Occup  (Give kind of work done to life. Do NOT use retired  19 Decedents Usual Occup  (Give kind of work done to life. Do NOT use retired  19 Decedents Usual Occup  (Give kind of work done to life. Do NOT use retired  19 Decedents Usual Occup  (Give kind of work done to life. Do NOT use retired  10 Decedents Usual Occup  10 Dec	Montague  ution, give street end number)  R STREET-BALTIMORE CITY JAIL  S. Sex    7. Age (In yrs. lest birthdey)   Hunder 1 Yeer   H Under 24 hrs.     10c. City. Town or Location   Baltimore	Montague    Continuity   Contin	Montague    2. Date of Deeth Dey SEPTEMBER 13,	Montague    Second   Second			

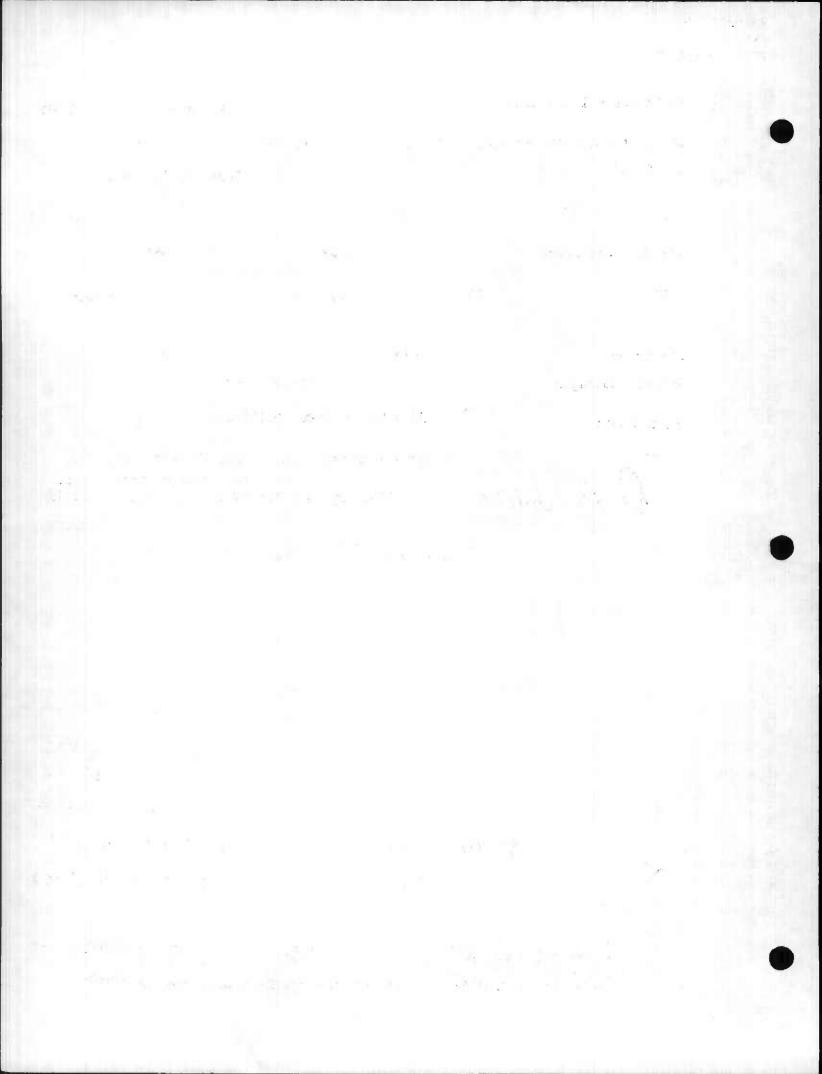
O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

deeth (Item 23e) (Type, Print)

32. Registrar's Signeture

SEPTEMBER 14, 1998



AUDE M	ITX	tem: 17 per F.H.G-763 9	State of Maryla /30/98 reb		ertificate of			Reg. No.	28	3/09			
Dhuo	ician	Decedent's Neme (First, Middle, Last)					2. Dete of De Month	eth Dey	Year	3. Time of Deeth			
Phys /Me	dical	CLAUDE MIX					SEPT.	17, 199	8	0300 AM			
Exar	niner	4a Fecility Neme (If not institution, give s LIBERTY MEDICAL				4b. City, Town, o BALTI	r Location of Death MORE	4c. County	of Deeth				
Funer Direct		5. Social Security Number 6. Sex 250-90-2911	M 2□F 7. Age (In yr	rs. lest birthday Yrs.	) If Under 1 Year Months Deys	If Under 24 Hi Hours Mi	n. (Month, De		9. Birthpled Country S.C.	ce (Stete or Foreign			
_		Usuel Residence of Decedent											
filed within 72 hours effer deeth with the Meryland Hygiena.		10e. Stete 10b. County		City, Town or L					10d	Inside City Limits  X  Yes 2 □ No			
	ecto	MD NA	В	altim				40-07					
	ă	10e. Street end Number			10f. Zip Code			10g. Citizen of V		11			
	era	1729 Gwynns Fa	2. Wes Decedent Ever in		21217 Wes Decedent of H If Yes, specify Cub		(Specify Yes or No	U.S.A 14. Race	e - American				
	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give		If Yes, specify Cubin 1 ☐ Yes 2 No		erto Rican, etc.)		k, White, etc Black				
"natural",	P	15. Decedent's Educ	Yeer or Dates:	16a Dece	edent's Usuel Occup	ation		16b. Kind of Bu					
in 72	Completed	(Specify only highest grade	completed)	(Giv	during most of w	rorking	TOD. KING OF BU	13111032111003	su y				
filed with Hygiena. ther than	mo	Elementery/Secondary (0-12)  12th grade	College (1-4or 5+) na	Lal	borer		1	Variou	s Job	S			
offie offi-	Be C	17. Fether's Name (First, Middle, Last)			18. Mother's N	ame (First, Middle,	Meiden Sumem						
should be nd Mental merked o	10	Eva Mao Mix LUT	HER C. MIX			Louis	e Belto	n					
end end a m		19e. Informent's Name/Reletionship (Ty)	pe, Print)	19b. Mei	ling Address (Street	end Number or i	Rural Route Numb	er, City or Town,	Stete, Zip Co	ode)			
alth alth		Betty Chatman-	sister		() Dianna	Road,							
o to		20e. Method of Disposition 1 Burial 2 □ Cremetion 3 □R	am aval from State	cemetery, cre	position (Neme of emetory or other ple		Dete	20c. Location -					
		4 □ Donetion 5 □ Other (Specify)			nd Heigh		9-21-98	Kersha	W, S.	.С.			
Departit Importa any Inju	SUC.	21. Signeture of Funeral Service Lican	201	ss of Facility 'H West									
Physicia /Medic	al	23a. Rarfi. Enter the disease, or complishock, or heart feilure. List only on Immediate Cause (Finel disease or condition	cetion that caused the dee ceuse on each line.	eeth. Do not er		ng, such as cardi	iac or respiratory e	rrest,	A	pproximete ntervel Between onset end Deeth			
Examin		resulting in death)  Due to (or es e consequence of):											
ed .	-lu	_ b											
be axecuted sician and buriel-transit	Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury c.											
0 % 0	Aedical	that initiated events resulting in deeth) Lest	Due to (or es e consequenca of):										
eath certifica attending ph I for use es th	Physician/Me	d							1				
death he atten ed for u	SICI	Pert II. Other significant conditions con	tributing to death but not r	esulting in the	underlying cause gi	ven in Pert I.	23b. Did tobacco use contributa to the cause of dec						
that the de led by the detached							10	Yes 2 No	3 Probe	bly 4 ☐ Unknown			
w requires that been signed b should be deta	Completed by						24e. Wes	en eutopsy ormed?	eveila	e eutopsy findings able prior to pletion of ceuse			
has has	ш						18	Yes 2□No	14.5	Ýes 2□ No			
tolan: The certificate rector, pag	CO	25. Wes case referred to medical				26 Place of F	eeth (Check only			165 2010			
Physician: r this certificated and director,	0 8	exeminer?	ospitel: 1 Inpatient	☑ ER/Outpatio	ent 3 DOA Ott	200	Home 5 Resi		er (Specify)				
g Phy er this	n: T	27. Menner of Death	28e. Dete of Injury (Month, Dey Year)	28b. Time				how injury occur					
Attending Fir deeth.  ector: After by the funer	atlo	1 Maturel 5 Pending investigation	9 17 48	A		Yes 2 100	54,72	er feu					
or Attend aftar deeth Director:	Certification:	3 Suicide 6 Could not be determined	28e. Piace of Injury - At building, etc. (Spe	t home, ferm, s	treet, factory, office		City or To						
irs aft al Dh			Porcu	4					10 BOUT	morrem			
To the Hospital or Atte within 24 hours after de To the Funeral Direct completaly filled in by t	edical	29e. Certifier 1 Certifying Phys (Check only one)	Ician: To the best of my k er: On the basis of exami end menner stated.	nowledge, des inetion end/or i	th occurred et the ti- nvestigation, in my o	me, dete end pla opinion, death oc	ce, end due to the curred et the time,	ceuse(s) and me dete end plece,	enner es stat end due to ti	led. he ceuse(s)			
within 2 To the	Me	29b. Signeture end title of certifier	1.		29c. Licens	se number		29d. Date signe	d (Month, De	ey, Year)			
- > - 0		Marketo On	Mule	un	O.C	.M.E		SEPT.	17, 1	998			
3		30 Name end eddress of person who co	mpleted ceuse of death (II	tem 23e) (Type	n Street,	Baltim	ore. Mary	land 21	201				
		31. Date filed (Month, Dey, Year)	32. Registrer's Sig		i sueer,	DOT CHIE	ore, imey						
	State	CED 2 1 10	QQ SZ. Megistrer's Sig	1	9 /20.	1.1							

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State of Maryl

and /	Department of Health an	a mentai	Hygie
	Certificate of Death		

Physician
/Medical
Examiner

Funeral Director

Director

Funeral

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the Meryland with

item 27 is marked other than "natural", or items 23s or 28s-f show other trsumstic event, the Madical Examiner must be notified at permit. Peges 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s eny injury or other traumatic event, the Madical Examiner must. Once.

3altimore, Maryland 21215-0020

**Physician** /Medical Examiner

physician and the 80 esn 8 peen certificate has or Attending Physician: After this funeral efter death Director:

Division of Vital Records, P.O. Box 68760

24 hours e completely To the To the To the I

Completed Examiner Physician/Medical by Completed Be P Certification: Medical

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day CATHERINE O'CONNOR SEPTEMBER 18, 1998 0955AM 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) BALTIMORE CITY

If Under 24 Hrs. 8. Date of SINAI HOSPITAL E.R. If Under 1 Yaar 8. Date of Birth (Month, Day, Year) MAR. 9, 1922 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign Days Hours Min. 1 □ M 2 ₩ F 76 Yrs. JAMAICA ID 105 01 8074 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location JAMAICA N/A WATERFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ST. CATHERINE 2136 FABLIC WAY JAMAICA 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Ricen, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Black, Whita, atc. 1 ☐ Yes 2 No If Yes, Give X Yaar or Datas: 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☒ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) SELF EMPLOYED Elementary/Secondary (0-12) College (1-4or 5+) DRESS MAKING DRESS MAKER N/A 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) IRENE MORGAN Mc CALLA HENRY LEWUIS Mc CALLA 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) CINDERELLA CURTIS (SISTER) 5501 WINNER AVE BALTIMORE, MD. 21215 20c. Location - City or Town, State JAMAICA 20b. Place of Disposition (Name of cematery, crematory or other placa) 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State DOVECOTT CEMETERY 9/24/98 4 ☐ Donation 5 ☐ Other (Specify) ST. CATHERINE, 21. Signature of Funeral Service Licensee LEWIS T. 22. Name and Address of Facilit
LEWIS T. GWY GWYNN FUNERAL HOME 21215-6393 GWYNN Televenn 4517 PARK HEIGHTS AVE. BALTO., MD. Part1. Enter the disease, or complications that causad tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) · Atherosclerotic Cardiovascular Disease Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part ff. Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Diabetes Mellitus 24b. Ware autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed?

25. Was cese referred to madical examiner? 1⊠ Yes 2□ No

27. Manner of Death

29a. Certifier

(Check only one)

1 Natural 5 Pending Investigation 2 ☐ Accident 3 Suicide

6 Could not be determined 4 Homicide

28a. Dete of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

MD

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred 1 Yes 2 No

INSPECTION

1 ☐ Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number O.C.M.E.

29d. Date signed (Month, Dev. Year) SEPTEMBER 18, 1998

3. Tima of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 Yas 2 No

1 Yes 2 No

30. Name and address of person who completed cause of death (frem 23e) (Type, Print)

Hospital:

Stephen Radentz, M.D.

111 Penn Street, Baltimore, Maryland 21201

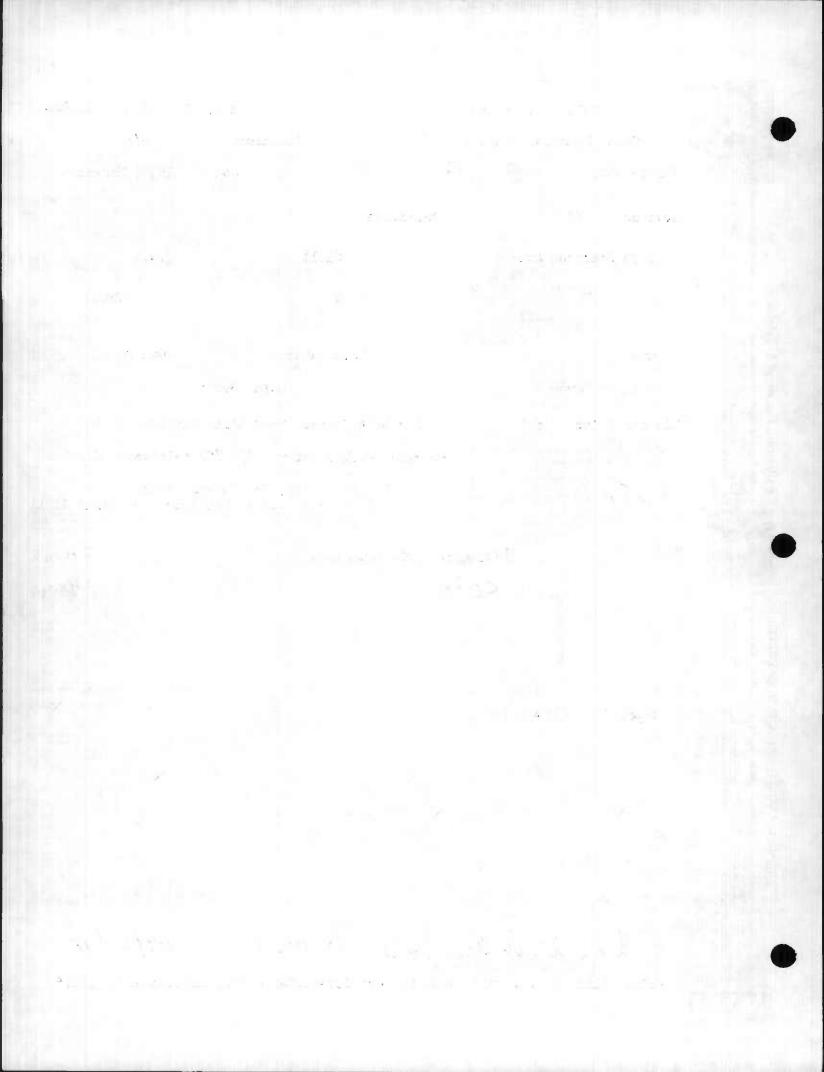
State Registrar 31. Date filed (Month, Dey, Year) SEP 2 1 1998

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

or items 23e or 28e infect must be not Funeral Direct	5. Social Security Nur 219-26-53 Usual Residenca of D	Wilma not institution, given memorianiber 6. s	F. Plit restreet and number Lal Hospi	er)			4b. City, Town, or Lo	2. Date of De Month	Day 18, 199		3. Time of Death		
or items 23e or 28±1 show and continue and c	Unio: 5. Social Security Nur 219-26-53 Usual Residence of D 10a. State Maryland 10e. Street and Numb	n Memori nber 6. S 20	tal Hospi Sex 7.	er) tal Age (In yrs. last		T	4b. City, Town, or Lo				1:30am		
or items 23e or 28e-f show to the confined manufacture and the confined manufacture or Funeral Director	Unio: 5. Social Security Nur 219-26-53 Usual Residence of D 10a. State Maryland 10e. Street and Numb	n Memori nber 6. s 20 recedent	ial Hospi	tal Age (In yrs. last			4b. City, Town, or Location of Deeth 4c. County of Death						
or items 23e or 28e-f show Dinier truthe Louis de Louis d	5. Social Security Nur 219-26-53 Usual Residence of D 10a. State 1 Maryland 10e. Street and Numb	20 eccedent 10b. County	Sex 7.	Age (In yrs. last		Union Memorial Hospital							
or items 23e or 28e-f show Dinier truthe Louis de Louis d	219-26-53 Usual Residence of D 10a. State  Maryland  10e. Street and Numb	20 recedent 10b. County			t hirthday)	If Under 1 Yeer	Baltimo	8. Date of Bit	N/A		as (State or Form		
o or thems 23e or 28e-f show and or prust be nounded y Funeral Director	10a. State 1 Maryland 10e. Street and Numb	10b. County		02	Yrs.	Months Døys		(Month, De	3, 1936	Country Mary			
y or tiems 23e or 28e-f sho actives fruit be roof ed y Funeral Director	10e. Street and Numb	N/A		10c. City, T	Town or Loca	ation				100	I. Inside City Lim		
y or Hems 23e or 28e- arricer must be nout y Funeral Direct	10e. Street and Numb	,		Ва	1timo:	re					1 TYPes 2		
arricer must be y Funeral Di	3633 C	er				10f. Zip Code			10g. Citizen of W	hat Countr	v?		
or Nems 23	3033 (	L + +	A = = = = = =			212	11						
y Fur	11. Marital Status	nestnut	12. Was Decede		13. W			ecify Yes or No	U.S.A	- Americer			
by by	1 Never Married		Armed Force 1 Yes 2[ If Yes, Give Year or Date	ΧNo		Yes, specify Cub ☐ Yes 2 No	ent of Hispanic Origin? (Specify Yes or fy Cuban, Mexican, Puerto Rican, etc.)  The No Specify:		Specify: Wh:				
natural.	. 1	5. Decedent's E	ducation	16a. Decedent's Usual O			pation		16b. Kind of Bu	siness/Indu	stry		
	(Specify	only highest gra	ada completed) College (1-4c	or 54)	(Give ki	ind of work done O NOT use retire	during most of work d)	ing	flooring and				
omp	unk	ary (0-12)	College (1-4)	5, 54,		Home N	laker		Own 1	Home			
36	17. Fathar's Name (Fi	irst, Middle, Last,	)				18. Mother's Name	e (First, Middle	, Maidan Sumam	9)			
	Wilme	r Gover					Lola	Burke					
traumatic To									ural Route Number, Cify or Town, State, Zip Code)				
	Michael Plitt (Son)  209 Belt Street, Snow Hill, Maryland  20e. Method of Disposition  1X Burial 2 © Cremation 3 © Removal from State  20b. Piece of Disposition (Name of cemetery, crematory or other place)  20c. Location - Cli										3		
or other											or Town, State		
any Injury or	1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Lorraine Park Cemetery 9/21/98 Baltimor										aryland		
g physician and as the bunal-traceit as the bunal-traceit ledical Examiner	disease or condition resulting in death)  Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in that initiated events resulting in death) La		a. ) 4142 b	Que to (or as	s a consequ	enca of):					YKAN?		
ed by the attending datached for use a	Part II. Other significa	iven in Part I	23b. Dtd tobacco use contributs to the cer			he cause of de							
by the tached		- 1	PASITS	T DOLLING TOO UK	ag in the time	son, ing occor g					the couse of death		
be da	MORBIT	) (1	ノルフリノフ										
ata nas been signed by the attending page 2 should be datached for use a Completed by Physician/M									s an autopsy formed?	evai com	a autopsy finding lable prior to pletion of ceuse aath?		
page page								10	Yes 2 No	10	Yes 2□ No		
rector, pag	25. Was case referred	d to medical					28. Place of Daat	h (Check only	one)	-			
00	examiner?	0	Hospital:	atient 2 ER	VOutpatient	3□ DOA Ot	her: 4 Nursing Ho	me 5□Res	ridenca 6 DOtha	ar (Specify)			
: After this e funeral di ation: To	27. Manner of Death 1 Natural 2 Accident	5 Pending investigatio		njury Day Year)	Bb. Time of Injury	28c, Inju Wo M 1	iry at ork? ] Yes 2 □ No	28d. Describe	how injury occurr	ed			
To the Funeral Director: After thi complately filled in by the funeral Medical Certification:	3 Sulcide 4 Homicide		28f. Location (Street and Number or Rural Route Nun City or Town, State)			Route Number,							
To the Funeral D complately filled i Medical Ce	29a. Certifier (Check only one)	Certifying Ph Medicat Exar	nyelclen: To the be niner: On the basis and mannar	of examination	dga, daath o and/or inve	occurred at the to estigation, in my	ime, date and placa, opinion, death occur	and due to the red at the tima	cause(s) and ma , data and placa, a	nner as sta and dua to t	ted. he cause(s)		
To the	29b. Signature and tit	le of certifier	1 -	n		29c. Licen	se number		29d. Date signed	(Month, P	ay, Year)		
	> /A	2 /	1 W. a	Adva.	m. D.	D	10661		09/	21/9	78		
4	30. Name and addras	s of person who	completed cause of	of death (Itam 23	3a) (Type, P				/		0		
							et,Suite	655. Ba	altimore	Md 2	21218		

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Day Month **Physician** BERDELLA REAVES 12:40 A.M. SEPTEMBER 16 1998 /Medical 4c. County of Death 4e. Fecllity Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner BALTIMORE ST. AGNES HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. | Months | Deys | Hours | Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1 M 2 F 97 220-24-1420 Yrs JUNE 30, 1901 Director Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 □ No BALTIHORE CITY Director MARYLAND 10e. Street end Number 10g. Citizen of Whet Country? 3619 DRIVE 21229 GELSTON USA Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yee, Give 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Maritel Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: BLACK 1 Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Elementery/Secondery (0-12) 8+HGRADE College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens important: If item 27 is marked other tha any fujury or other traumatic avent, train once. HOMEHAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be VIRGIL ELIZA KELSON 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3631 GELSTON DRIVE, BALTIHORE, MD. 21229
ace of Disposition (Name of Dete 20c. Location - City or Town, Stete ENA HOLLOWAY (DAUGHTER) 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 1 Burial 2 □ Cremetion 3 □ Removel from State 9-21-98 BALTIHORE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) BALTIMORE NATIONAL 23a. Pert. Enlar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory errest,

Approximate Physician /Medical Immediate Ceuse (Finel e. END STAGE CONGESTIVE HEART FAILURE FIVE YEARS disease or condition resulting in death) Examiner Due to (or es a consequence of): Physician/Medical Examiner 48 HOURS UROSEPSIS Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of) P.O. Box 68760, Due to (or es e consequence of): SBS Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 □ Unknown signed t HYPERTENSION Records, þ 24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? 24e. Wes en autopsy performed? Be Completed ATRIAL FIBRILLATION 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No this certificate of Vital or Attending Physician: 25. Wes cese referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Division After 5 Pending Investigation 1 Naturel 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) in by 4 Homicide To the Hospital or within 24 hours aft To the Funeral Dil completely filled in 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Moholethe, MD P12593 SEPTEMBER 16, 1998 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ST. AGGES HOSPITAL, 900 CATON AVENUE, BALTIMORE, MARYLAND 21229

32. AGGES HOSPITAL, 900 CATON AVENUE, BALTIMORE, MARYLAND 21229

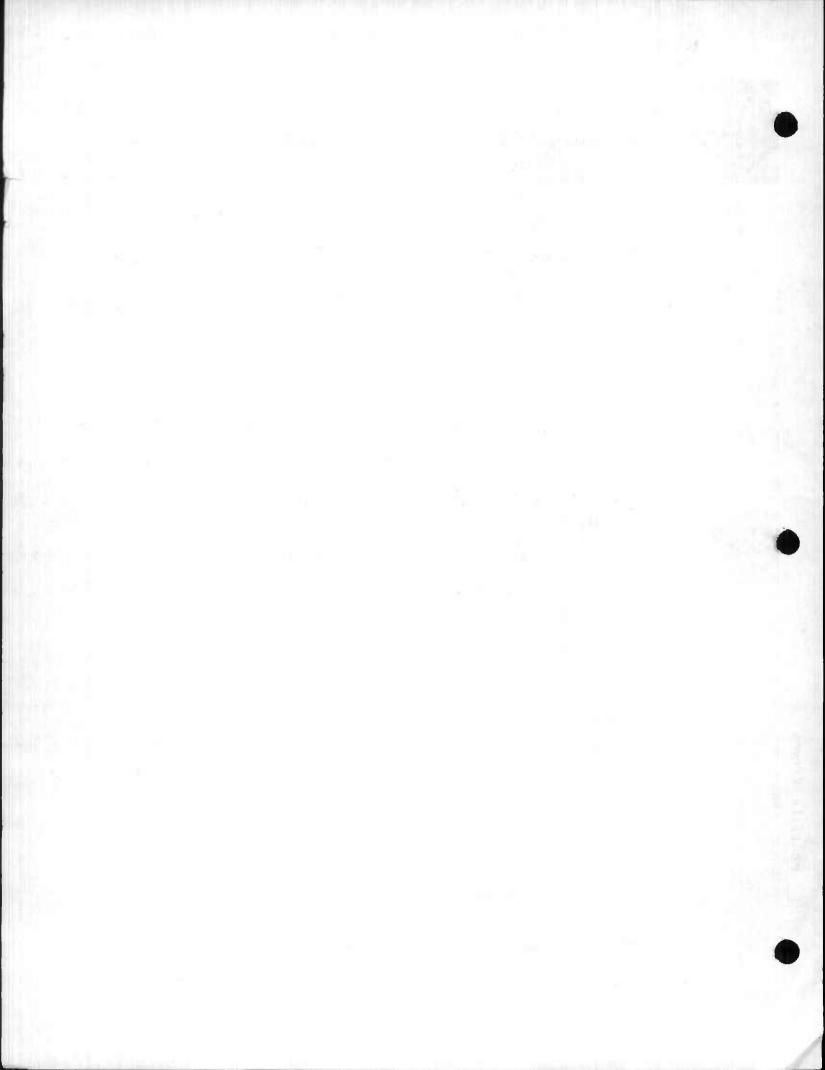
Registrar

State

MOHAMMAD Y. KHAN, M.D.

REAVES

BERDELLA



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** September 17, 1998 10:00 Pm Pauline Virginia Reynolds /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium Baltimore If Under 1 Year 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1□M 2□F 76 YIS. Director 20, 1922 217-12-5401 Aug. Maryland the Menylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or itema 23a or 28e-f show the Medical Exampler must be notified at MD Baltimore Timonium 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2027 Reuter Road 21204 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 72 hours efter 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 DWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Peges 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nationy or other treumatic event, the Maries page. 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Sales/Sears 17. Father's Name (First Middle Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) Be Muriel Martin Mertil Pauline Hunt 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 329 Kendig Drive Owings Mills, Maryland Mr. Jim Reynolds/son 21117 20a. Method of Disposition

14 Burial 2 Cremetion 3 Removel Irom State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Grdns 09/21/98 Timonium, Maryland 21. Signeture of Fungfel Service Licenstephen Oster 22. Name and Address of Facilitruck Towson Funeral Home, Inc. 1050 York Road Towson Maryland 21204 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failura. List only one cause on each line. Approximeta Intervel Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Inforction Nyocardial Examiner Due to (or es a consequence of) Examine **buriel-trensit** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pug Due to (or as a consequence of): physician s the buriel Box 68760 edicai Due to (or es a consequence of) Physician/M 080 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy lindings eveitable prior to completion of cause of deeth? Completed 24e. Wes an autopsy parformed? this certificate 1 ☐ Yes 2 No Division of Vital 25. Wes casa refarred to medicat examiner? Be 26. Place of Death (Check only one) 1 Yes 2 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Marsing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death

1 Natural

2 Accident 28b. Tima of Injury 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending invastigation ofter death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

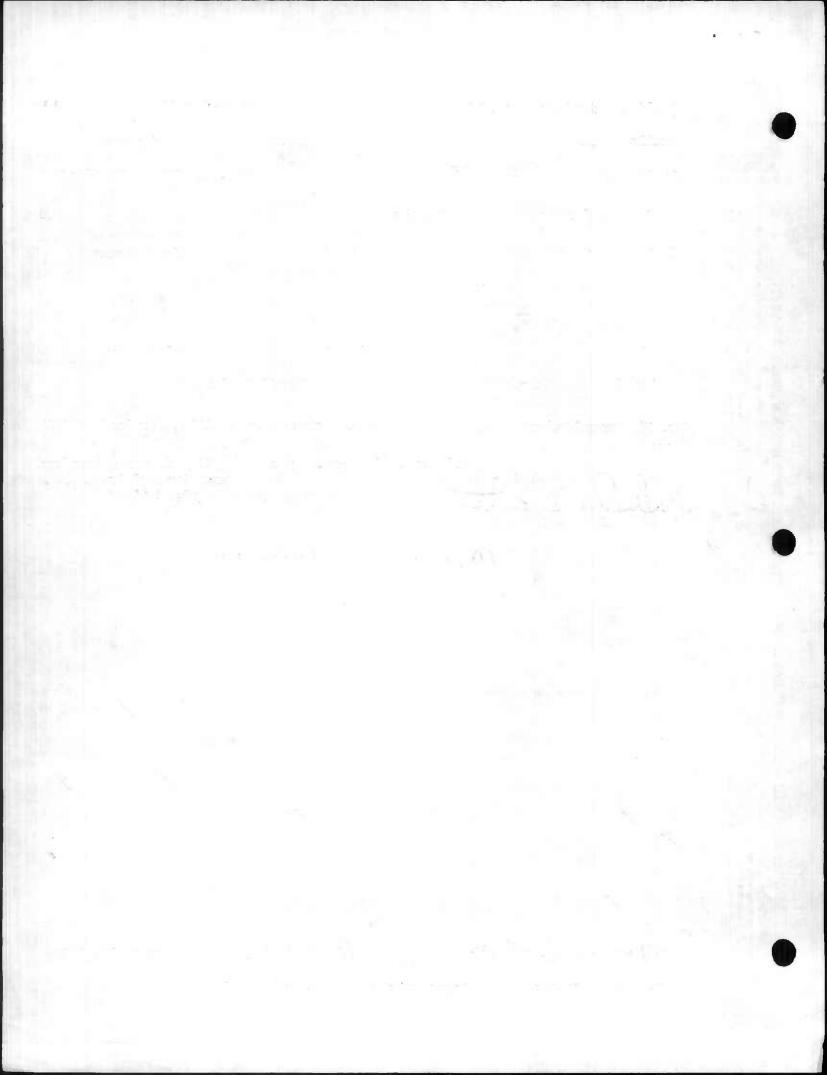
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Cartifier (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 18, 1998 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) Dr. Mark Stromberg 7505 Osler Drive Towson, Maryland 21204 31. Date filed (Month, Day, Year) SEP 2 1 1998 32. Registrar's Signature State

**DHMH 16 Rev 6/95** 

Registrar

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State of Maryland / Department of Health and Mental Hygiene 28. 28711

Physician Medical Exchanges of the control of the several formation of					C	ertifica	ate of L	Death		Reg. No.		)     4
EXPITION DIVISION TO PARTITION AND ALLE ROUNDS			1. Decedent's Name (First, Middle, La	ist)						Death	Vana	3. Time of Death
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Physician Medical Examiner    Sequence of the property of the			23a. Part1. Enter the disease, or com	plications that ceused th	ne death. Do not	enter the m	ode of dyln	g, such as cer	diac or respiratory	arrest,	TORE	Approximate
Due to (or as a consequence of):	Physici:	an	SHOCK, OF HEART TARRIES. LIST OTHY	one cause on each line	•							Onset and Death
Due to (or as a consequence of):  Sequentially list conditions cause. Characteristic cau		_	Immediate Cause (Final	Stab	1.62	-1	-1	No	de		1	
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d.    Continue   Conti	68 ficate	ed i	resulting in death) Last  Due to (or as a consequence of):									
1   Yes 2   No   1   Yes 2   Yes 2	Certific Cer	3		d								
1   Yes 2   No   1   Yes 2   Yes 2	Batte attention	Cia							1			
24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?  25c. Was cese referred to medical examination and or investigation in my opinion, death of the course of the page	She be o	ysi	Part II. Other significant conditions of	ontributing to death but	not rasulting in th	e undarlying	g ceusa giv	an in Part I.		-		
242. Was an autopsy performed?  246. Were autopsy findings available prior to completion of cause of death?  1	deta deta	4							11	Yes 29No	3∐ Prol	bably 4 Unknown
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O.C.M.E. SEPTEMBER 13, 1998  30. Nama and addrass of person who completed ceuse of death (Item 23a) (Type, Print)  111 Penn Street, Baltimore, Maryland 21201  State  31. Date filed (Month, Day, Year)  32. Registra's Signature	D Partie	9	, grieniste.	/1- \	OV	buile	ding		400	614 C	whoo	lrul 54
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				1008 32. Registrar	s Signature	13.	apar	15/				

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State of Maryland / Department of Health and Mental Hygiene Amend: #8 Per FH Film G763 9-23-98RC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** September 1,40 P.M. Joseph R. Seborowski 1998 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner CenTer Rosedale
less birthday) If Under 1 Year If Under 24 Hrs. 8. Date
Months Days Hours Min. Mo FRANKLIN SEMANTE HOSPITA BALLIMORE 8. Date of Birth (Month, Dey, Yeer) 1924 9. Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 1₽M 2□F 218-18-2956 74 **Director** July 22, 2924 Maryland Usual Residence of Decedent the Marylend 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Perry Hall 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be 1 4705 Lavington Place 21236 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1⊈Yes 2 □ No If Yes, Give Year or Dates: WW II 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status Black, White, etc. 1 Never Married 25 Married 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Shipping 10 yrs. Long Shoreman 18 Mother's Name (First Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Be 1 end 2 should be 1 Health and Mental I Adam Seborowski Anna Piotroska 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Health a Peges 1 en nent of Healt nt: If Item 27 y or other tr Veronica F. Seborowski/Wife 4705 Lavington Place Baltimore, Maryland 21236 Baltimore, 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, State \$☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Joseph Church Cemetery9/21/98 Fullerton, Maryland 21. Signature Furteral Sery be Licens 22. Name and Address of Fecility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 cations that called the co 23a. Part1. Enter the disease of complishock, or heart failure. List only of Approximete Intervel Between Onset end Death e death. Do not enter the mode of dying, such as cardiac or respiratory arrest **Physician** /Medical Immediate Cause (Final PSI disease or condition resulting in death) Examine Due to (or as a consequence ot): Examiner er Tonitis 1 physician end the bunal-transit that the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequenca ot): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 80 USe signed by the a d be detached f 23b. Did tobacco use contribute to the ceuse of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 2 No 3 Probably 4 Unknown 1 Yes þ 24b. Were autopsy findings available prior to 24e. Was en eutopsy Completed completion of cause of deeth? i certificate has t 1 ☐ Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Netural 2 Accident 5 Pending 1 Yes 2 No r deeth. investigation 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Direc Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) and menner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end pleca, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one) Within To the 29d. Date signed (Month, Dey, Year) 29b. Signature and fittle of certified 29c. License number when Hermon September 18,1992 empided cause of deeth (Item 23a) (Type, Print) 30. Name and eddress of person er 9000 Franklin Square Drive Baltimore, Haryland 21237 Herman Jun 31. Dete filed (Month, Dey, Yeer) SEP 2 1 1998 32. Registrar's Signature State

**DHMH 16 Rev 6/95** 

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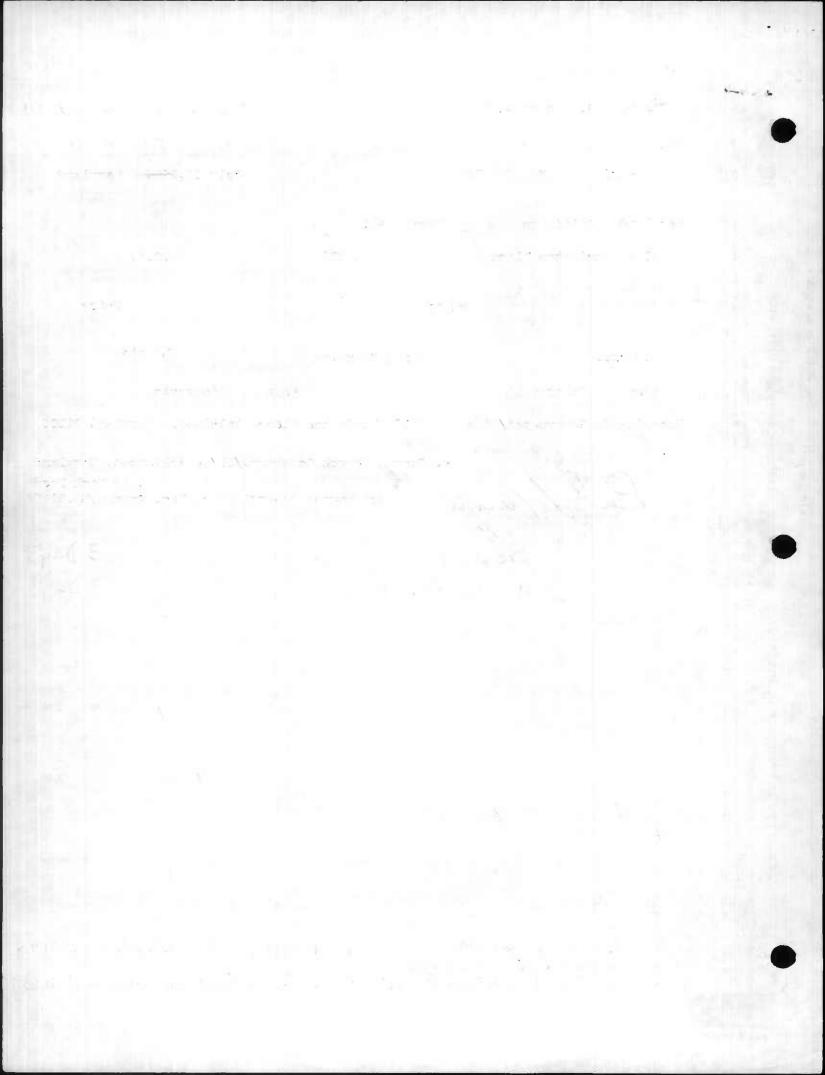
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Intisar Syed Eptember 16, 1948 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death ALTIMORE (17 n/a MARYLAND 5. Social Security Number GENERAL HOSPITAL If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. lest birthday) Birthplaca (State or Foreign Country) Days Months Hours 214-46-2131 51 Yrs March 31, 1947 Md. Usual Residence of Decadent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits n/a Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1712 McCulloh Street 21217 USA Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Information System Elementery/Secondery (0-12) College (1-4or 5+) City of Baltimore Data Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alex Harris Corrine Kane 19e. Informant's Name/Reletionship (Type, Print) husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Cason 1712 McCulloh Street Baltimore, Md. 21217 20b. Piaca of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Burlal 2 Cremation 3 Removel from State King Memorial Park Sept. 18 Randallstown, Md. 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funerel Service Licensee 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation

**Physician** /Medicai Examiner

certificate be

Division of Vital Records,

**Physician** 

/Medical

Examiner

Md.

Director

Funeral

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**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

end Mantal Hygiana.

permit. Peges 1 end 2 s Department of Health er Important: If item 27 is any injury or other trau

Peges 1

Examiner

attending physician and for use es the bunel-trans has funeral death.

Physician/Medical Certification: after death Director:

þ Completed Be

Medical

1 Yes 2 No

1 Neturel 2 Accident 3 ☐ Sulcide 4 Homicide

(Check only one)

29a. Certifier

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28e. Piace of Injury - At home, farm, street, factory, offica building, etc. (Specify)

1 Tyes 2 □ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of cartifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) chuartz, m.D. 40

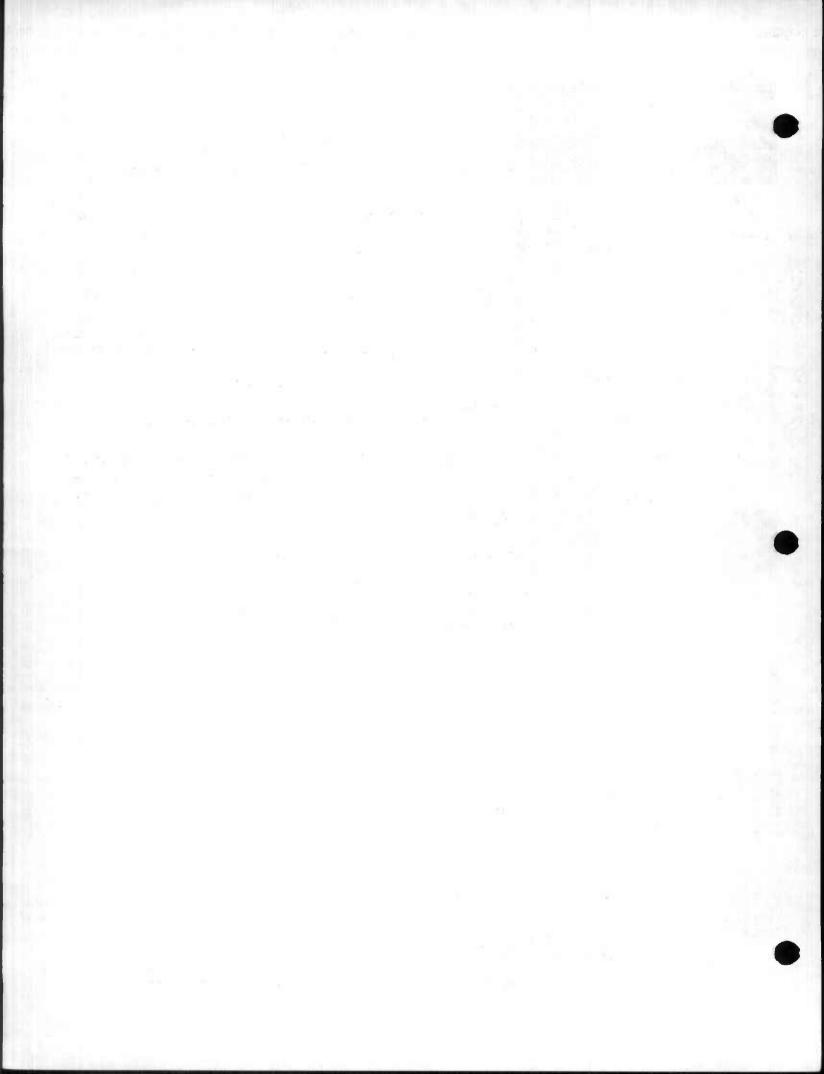
32 Registrar's Signature

Maryland General Hospital

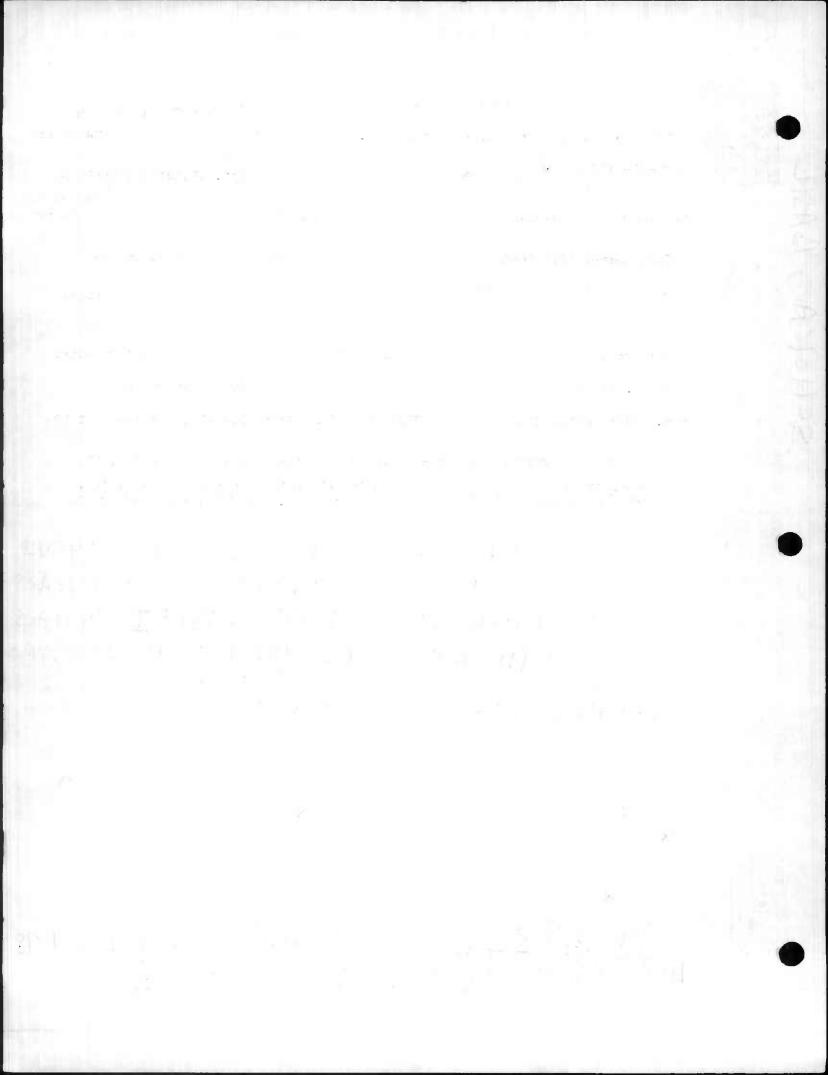
State Registrar

Fumeral

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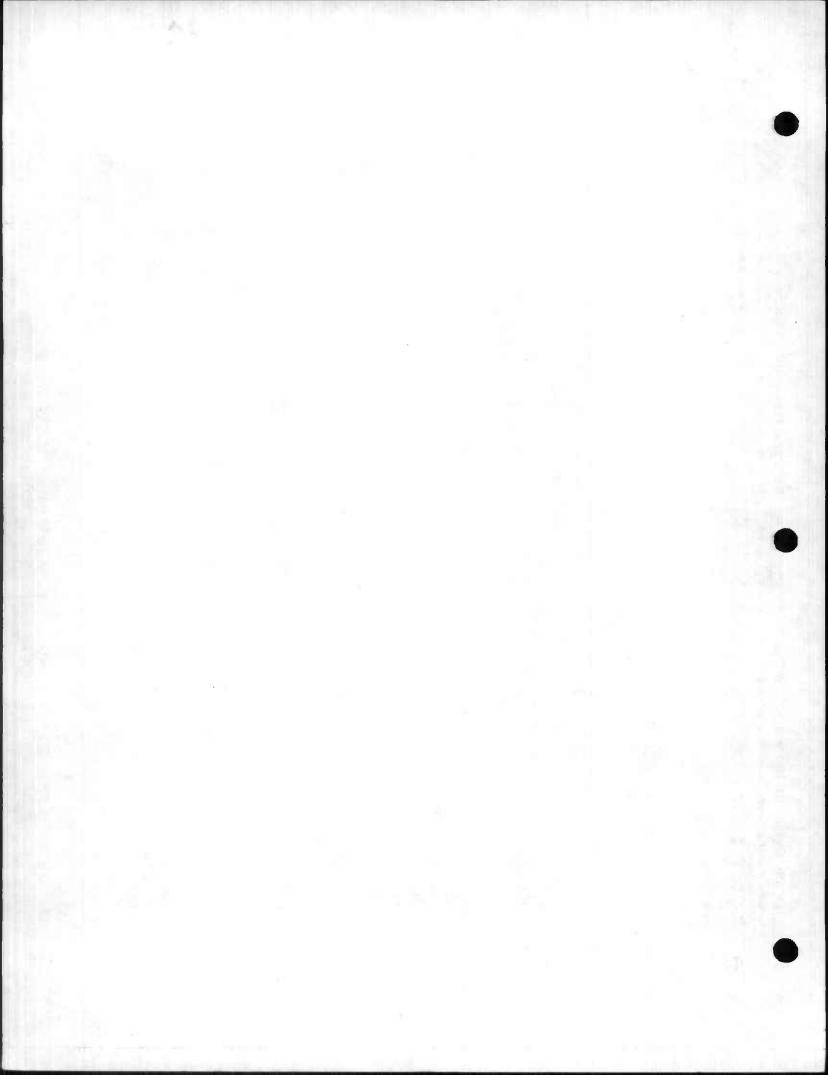


		1. Decedant's Name (First, Middle, La	nst)		rtificate of		2. Date of Dee	eg. No.	3. Time of Deeth
Physicia /Medic			Basi			choka	Month Septem	Dey Ye	998 4 PM
Examin	er	4a. Fecility Neme (If not Institution, gir Genesis Heritag			Ctr.	4b. City, Town, or L Dundal		4c. County of E	Baltimore
Funeral Director		209-03-0113	Sex 7.7 1 ☑ M 2 □ F	Age (In yrs. last birthdey) Yrs.	Months Deys		8. Date of Birth (Month, Dey Aug • 28	(Year) 9,1917 Pe	Birthplace (Stete or Forei Country) nnsylvania
M N		Usual Residence of Decedent  10e. Stete 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limit
ath with the Marylen 23a or 28a-f show	ctor	Maryland Ba	ltimore			Dundalk			1 □ Yes 2 <b>₹</b> \$₹
Mith th	Director	10e. Street end Number			10f. Zip Code			0g. Citizen of Whe	•
708 23 708 23	Funeral	7232 German Hil	12. Was Deceder	nt Ever in U,S. 13.	Wes Decedent of I	21222 Hispenic Orlgin? (Speen, Mexican, Puerto			American Indien,
72 hours effer death with the Maryland natural; or items 23s or 28s-f show seal Examinar must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force: 1 ☐ Yes 2 2 If Yes, Give Year or Dates	I No	If Yes, specify Cub 1 ☐ Yes 2 A No		Rican, etc.)	Specify:	White, etc. White
within 72 hours iene. then "netural", he Med cal Ex	Completed	15. Decedent's E (Specify only highest gra Elementery/Secondary (0-12)	ducation ade completed) College (1-4o	(Give life.		during most of work ed)	ing	16b. Kind of Busine	
0 0		Not Known  17. Fether's Name (First, Middle, Last	)	Ste	eel Worke	18. Mother's Nem	e (First, Middla, i		Industry
should be ind Mental i marked or umatic eve	To Be	Ignotz Schoka				Sop	hie	(Not Kno	wn)
d the start		19e. Informent's Name/Relationship (Mrs. Dolly Morris				tend Number or Rui nire Road			
Peges 1 e ent of Her nt: If Item ry or othe		20e. Method of Disposition  1 ☐ Buriel 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specia		0	matory or other pla	(ausoleum		20c. Location - City	
permit. Peges 1 en Department of Heel Important: If item 2 any injury or other once.		21. Signeture of Funeral Service Lice			2. Name end Addre Duda-Ruc	ess of Fecility ck Funeral	. Home o	f Dundalk	, Inc.
_		23a. Pert1. Enter the disease, or comshock, or heert failure. List only	plications that caus	ed the death. Do not en		se Ave. I			Approximete
Physician			_	. 0					Interval Between Onset end Death
/Medical Examiner		Immediata Causa (Final disease or condition rasulting in deeth)	COK	ONAKY Due to (or as e conse	111	ERT	D(2)		10 YEAR
and I-transit	Examiner	Sequentially list conditions,	b. L33	Due to (or es e conse	quence of):	1715	CIEN	USION	187 EA
bur join	edicai E	Sequentially list conditions, if eny, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that Initiated events	DIH	Due to (or es e consec	Juence of):		12 1	FET	257EH
= 00		resulting in deeth) Lest	CHR	onic o	DOTUI	CTIVE	= PUL	MONAI	2420YEA
deeth certific e attending p ed for use es	cian					D(3	SEASE		1
0 0 0	Physician/M	Pert II. Other elgnificent conditions of	ontributing to death	III A R	ACC [	ven in Pert I.	23b. Did to		oute to the ceuee of dee ☐ Probably 4 Unknown
es th	by	CLAUDEU	4110	0411	ACCII	Driv I			
law requires that the tes been signed by the 2 should be detached	Completed						24a. Wes e perfor		4b. Were eutopsy finding eveileble prior to completion of cause of deeth?
sician: The lav certificate hes irector, pege 2		05 11/2					1 <b>X</b> Y		1 ☐ Yas 2 No
s certif	To Be	25. Wes case referred to medical examinar? 1 ☐ Yes 2 ☐ No	Hospital:	tient 2 ER/Outpetler	nt 3 DOA Ott	26. Plece of Deet		enca 6 □Othar (	Spacify)
ding Phys h. After this funeral di		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Dete of In (Month, D					ow Injury occurred	
Afgigital or Attending Physician: The is fugacian death. Fugacian Director. After this certificate he stell filled in by the funeral director, page	Certification:	2 Accident Investigetio 3 Suicide 6 Could not b 4 Homicida		njury - At home, farm, str atc. (Spacify)		]Yes 2□No	28f. Location (Si	treet end Number o	r Rural Route Number,
o first or start of the start o		Torricioa	building, a	атс. (Эраспу)			City or Town	1, S(e)(a)	
ESEC	Medicai	(Check only 2 Medicel Exer	yelcien: To the bes niner: On the basis and manner s	t of my knowledga, deet of examination and/or in steted.	vastigation, in my	opinion, daath occur	red at tha tima, d	ata and placa, end	due to the ceuse(s)
With Common		29b. Signature and title of conditor	lingh,	~D	29c. Licen:	5 1416	0 8	SEPTEM	BER 15, 19
		Halfe and addices of beiso Sylp	Culbised for sale	ALT (MO	SEA K	You!	419	31399	L)
					1 1 1 1				



State of Maryland / Department of Health and Mental Hygiene

	_	Decedent's Name (First, Middle, La	eet)		te of Death		Reg. No. 98	2.0 /   8
	hysician	Mildred	Sephonne			Month		98 0819Am
20.7	/Medical xaminer	4a Facility Name (If not institution, gir			4b. City, Town, or	Location of Death	4c. County of	Death
		Singi Hospi	tal			nore	NA	<i>}</i>
	neral ector	5. Social Security Number 76. S 214-40-5657 Usual Residence of Decedent	Sex 7. Age (In yrs. 1□ M 200 F	Months	r 1 Year If Under 24 Hrs Days Hours Min	(Month, Day	7. Year) -1905	Birthplace (State or Foreign Country)
puel/	ST S	10a. State 10b. County	10c. Cit	ty, Town or Location				10d. Inside City Limits
Men	rector	·Md	NA BO	altimire				1 No Yes 2 No
	dos matte notified	10e. Street and Number 2/ C Hami	11 Road	10f. Zi	21210		10g. Citizen of Who	et Country?
_ 3 4		11. Marital Status  1 Never Married 2 Merried  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces?  1  Yes 2  Yo If Yes, Give Year or Detes:	,S. 13. Was Dece If Yes, spe 1 Yes	dent of Hispanic Origin? (Socity Cuban, Mexican, Puer 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Bleck, Specify:	American Indien, White, etc.
5-0 72 ho	9	15. Decedent's E	ducation	16a. Decedent's Use	ial Occupation	utina	16b. Kind of Busin	ness/industry
21215-0020 d within 72 hours of piens.	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	0	ork done during most of wo use retired)	in King	Schoo	1
CA AB	event, the b	17. Father's Name (First, Middle, Last	Masters	Princi		me (First, Middle,	Maiden Sumamel	
d be d		Tohn W. Ton	01		14010	John		1
- 4 P	EĘ	19a. Informant's Name/Relationship	Type, Print)	19b. Meiling Addres	s (Street and Number or R	1		ate, Zip Code)
	4	Carolyn Wainwr	ight - Cousin	2333 Eu	tan Place &	Baltimore	, ud .	21217
0 275	or other t	20a. Method of Disposition 120Burial 2 ☐ Cremetion 3 ☐	20b. F	Place of Disposition (Na cometery, crematory or	me of	Date	20c. Location - Ci	ty or Town, Stete
Page ment of	Injury o	4 Donation 5 Other (Special		+aubum	Cemetery	9-18-98	Balto, A	ed 21230
Baitimo	eny in	21. Signature of Funeral Service Lice	w and	22. Name e	nd Address of Facility RF, H. Wls OD Walbash	+ Grenn	e Bal	to red 21215
1		23a. Part1. Enter the disease, or com shock, or heart tailure. List only	plications that caused the deet one cause on each line.	h. Do not enter the mo	de of dying, such es cardia	c or respiratory er	rest,	Approximate Interval Between
Physi	ician dical	Immediate Cause (Finel	10	1-0	1 1			Onset and Death
Exam		disease or condition resulting in death)	a		In forctio	7		Minustes
	ě		Hupen Te	or as e consequence of	art Mileau			Year
Sur Cate	burlai-transit	Sequentially list conditions,	0.	or as a consequence of				1
90,	E E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c					
86	E .	that initiated events resulting in death) Last		r as a consequence of)				4
Box 6	W.		d					
D H	d for	Part II. Other significant conditions of	contributing to death but not res	ulting in the underlying	cause given in Pert I	23h Did 1	obacco use contr	ibute to the cause of death?
P.O.	be deteched for use by Physician/M	The state of the s	Uplealor Sc		ozado givan zir on i.	101	. /	□ Probably 4 □ Unknown
S. I	by by			CIBCOLL				
lew requires that the death cer	une certificate res books agained by the accounting all director, page 2 should be detached for use as:  To Be Completed by Physician/Me	Mitral Re	gorgitation			24a. Was a	an autopsy med?	24b. Were eutopsy lindings eveileble prior to completion of cause
Sec.	mpl						/	of death?
A Para	S					1 D Y		1 ☐ Yes 2 ☐ No
of Vita	To Be	25. Was case referred to medicat examiner?  1 Yes 2 No	Hospitel: 1 ☐ Inpatient 2 ☐	VER/Outpatient 3□ D	Other	eth <i>(Check only o</i> Home 5 Resid		(Speciful)
Division of Vital Records, or Attending Physicien: The lew requires the first death.	funeral d	27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)		28c. Injury at Work?  1 Yes 2 No	_	ow injury occurred	
Olvisi or Atten	ed in by the funeral Certification:	3 Suicide 6 Could not be determined	e con Diago of Johnson Ath	ome, lerm, street, lecto y)	ry, office	28f. Location (S City or Tow	Street and Number m, Stete)	or Rural Route Number,
DIVISION OF To the Hospital or Attending Physical Attending Physical Control of the Fundant Director; After this	pletaly filled edical C		nysician: To the best of my kno niner: On the basis of examine and manner steted.					
o the children	Me M	29b. Signature and title of certifier		29	c. License number		29d. Dete signed (	Month, Day, Year)
		two & Br	/nz		122031	+	9-11-9	8
	0	30. Name and address of person who	completed cause of death (Item	n 23a) (Type, Print)	1 10 n	1/ 4/	^	. 0
		DR. LARRY S. F	ERRY 2116	MARYLAND	1 Mue 131	alto M	212	118
Re	State egistrar	31. Date filed (Month, Day, Year)	1998 Depart	geture &.	Sparks			



		4 B	14-1-1		001	tificate of	Doutin		Reg. No.	1 /	<del>0-/</del>
Physicia	an	Decedent's Name (First, Mid	idie, Last)					2. Date of D Sept.		Year	3. Time of C
/Medic	al	Sallie Su	isanne Sme	dley					19°,199		9:15
Examin	er	4a. Facility Name (If not institute 932 Leiste					Westmir	or Location of Dee		of Deeth	
					to a filtrate at a 1	If Under 1 Yeer					
Funeral Director		5. Social Security Number 215–30–3169	6. Sex 1 □ M 2/1/2 7.	Age (In yrs. i	Yrs.	Months Days		n. OCT •	10,1933	9. Birthpla	yland
natural, or items 23a or 28a-f show dical Examiner must be notified at		Usual Residence of Decedent 10a. State 10b. Coun	ity	10c. City	y, Town or Loc	eation				100	d. Inside City
t show	5	Md. Car	roll		tmins					1,0	1 Yes
289	Director	10e. Street and Number	. 1 011			10f. Zip Code			10g. Citizen of V	What Countr	v?
3a or	O	932 Leis	sters Chur	ch Rd			157		U.S		,.
Tag 5	Funerai	11. Marital Status	12. Wes Decede	nt Ever in U,S	S. 13. W	as Decedent of I	Hispanic Origin?	(Specify Yes or Nerto Rican, etc.)	o- 14. Rac	e - Americe	
"natural", or items 23a or 28a-f show ledical Examiner must be notified at	by Fur	1 Never Merried 2 Ma 3 Widowed 4 Provorce	If Yes, Give	No		Yes, specify Cub  ☐ Yes 2 No		erto Rican, etc.)	Specify.	k, White, et Whi:	
eate	Pa	15. Decede	ent's Education		16a. Decede	ent's Usual Occu	petion		16b. Kind of Bu	usiness/Indu	istry
	Completed	(Specify only high Elementery/Secondary (0-12)	nest grade completed)	Dr. 5.1\	(Give k	ind of work done O NOT use retire	during most of v	vorking			
rlygiana. ther than	E	11	) College (1-40	JI 3+)	Assis	tant Ad	dminist	rator	Nursin	g Ho	me
d othe	Bec	17. Father's Name (First, Middle	. ,					ame (First, Middle		10)	
	ToE	Horace	Waters La	ir, J	r.		Arthu	retta :	Fitz~		
th and Mantal 7 is marked of traumatic ever		19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailing	g Address (Stree	t end Number or	Ru <i>rai Rou</i> te Numi	ber, City or Town,	Stete, Zip C	<sup>200de)</sup> 211
= 01 L		Susanne Str	rine-Daugh	ter	932	Leister	rs Chur	ch Rd.	, Westm	inst	er, M
5 = 0		20a. Method of Disposition  1		te WO	lace of Disposementery, cremited and Control (Control (Co	ition (Neme of etory or other pla n Ceme	tery Se	pt. 23	20c. Location -	City or Tow	m, State awn,
Tain.		21. Signeture of Funeral Service			22.	Name and Addre	ess of Facility	al Cha	nel		
n y i					H:						
Assiciant important: if important: if important: if amiliery or any injury or any inju		23a. Part1. Enter the disease, shock, of heart failure. Li	or complications thet cause st only one ceuse on each	-AD1	n. Do not ente	296 Ch: or the mode of dyi	ermil I	mail of Mail	ncheste	r, M	Approximate interval Betwo
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Month 000 **Physician** romas GEORGE 98 September 17. AH /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, giva street end number) 4c. County of Death Examiner Medical Center BALTIMORZ 6. Sex 1 Ø M 2 ☐ F If Undar 24 Hrs. If Under 1 Year Birthpleca (State or Foreign Country) 5. Social Sacurity Number 7. Aga (In yrs. lest birthday) **Funeral** Deys Vrs **Director** 212-40-0410 55 43 M.D. Usuel Residence of Decedent with the Maryland 10e. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "naturel", or items 23s or 28s-f show the Modical Examiner must be notified at 1X Yas 2 No Director MD Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? deeth v Funeral 3424 Edmondson Ave 21229 U.S.A 14. Race - Amarican Indien, Bleck, White, etc. 12. Was Dacedant Evar in U,S. Armad Forces? Was Dacedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status Id be filed within 72 hours after de ental Hygiene. ked other than "naturel", or frem c event, the Modical Examiner is 1 ☐ Yes 2 ☐ No If Yas, Giva Yeer or Detes: Never Marriad 2 Merried 1 ☐ Yes 2 ◯ No Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/industry Elemantary/Secondery (0-12) College (1-4or 5+) Beth Steel 12th grade 17. Fether's Neme (First, Middle, Last) Laborer permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If item 27 Is marked other any Injury or other traumatic event once. 18. Mothar's Nama (First, Middla, Meiden Sumeme) Be George W. Thomas Sr. Ann Butler 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Streat end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1616 Bramble Ct, Belair Md
Placa of Disposition (Nama of cametery, cremetory or other placa)

Data 20c. Li 21014 Julia Green-Sister 20c. Location - City or Town, Stete 20b. Placa of 20a. Method of Disposition 1 Buriel 2 Crametion 3 Removal from State 4 Donetion 5 Other (Specify) Mt. Auburn Cemetery 9-21-98 Baltimore, Md 21. Signatura of Funarel Sarvice Licensee 22. Name and Addrass of Facility March F/H West 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert feilure. List only one cause on each line. 21215 Approximate Interval Between Onset and Deeth **Physician** /Medical Immediata Causa (Final diseese or condition rasulting in daath) Examiner Physician/Medical Examiner law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Disaasa or Injury that Initioted events resulting in deeth) Last Dueumou rea P.O. Box 68760. Due to (or es a consequenca of) Se ettending USB signed by the e Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uge contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ng vinal Division of Vital Records. þ 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? eniza. ils certificate has t director, page 2 s In as coudifice The 2 X No 1 ☐ Yas 2 No 1 Yes Physician: 25. Was casa referred to medical Be 26. Place of Death (Check only one) axaminer? Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yas 2 No P this 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred Certification: 28c. Injury at Work? After Hospital or Attending 1 Naturel 5 Panding invastigation 1 Yes 2 No To the Hospital or Attendit within 24 hours efter death.

To the Funeral Director: All completely filled in by the fu death. 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 6 Could not be 28a. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) end mannar as stated.

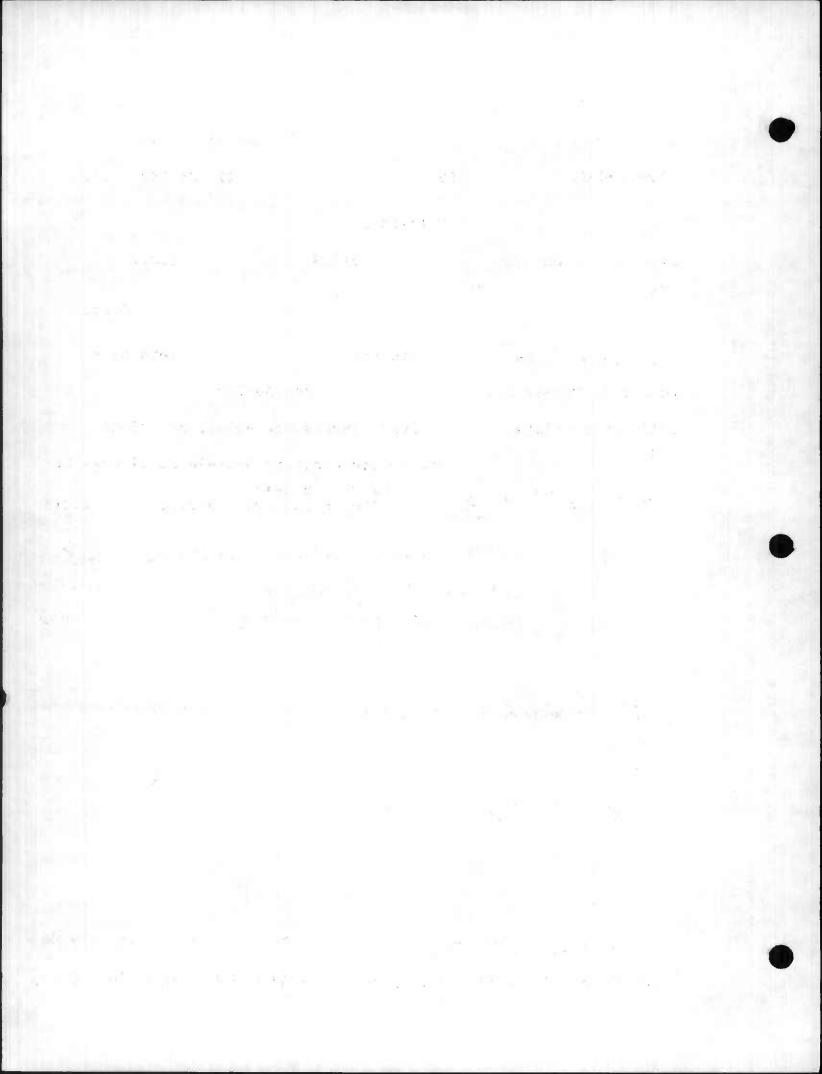
Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, daeth occurred et the time, deta end place, and dua to tha ceuse(s) end mennar stated. 29e. Cartifier edical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and titla of cartifier 29c. License number D 30. Name end eddress of complated cause of daeth (Item 23e) (Type, Print) BATTIMORE. MD. 21215 boo Liberty WANG

Registrar

State

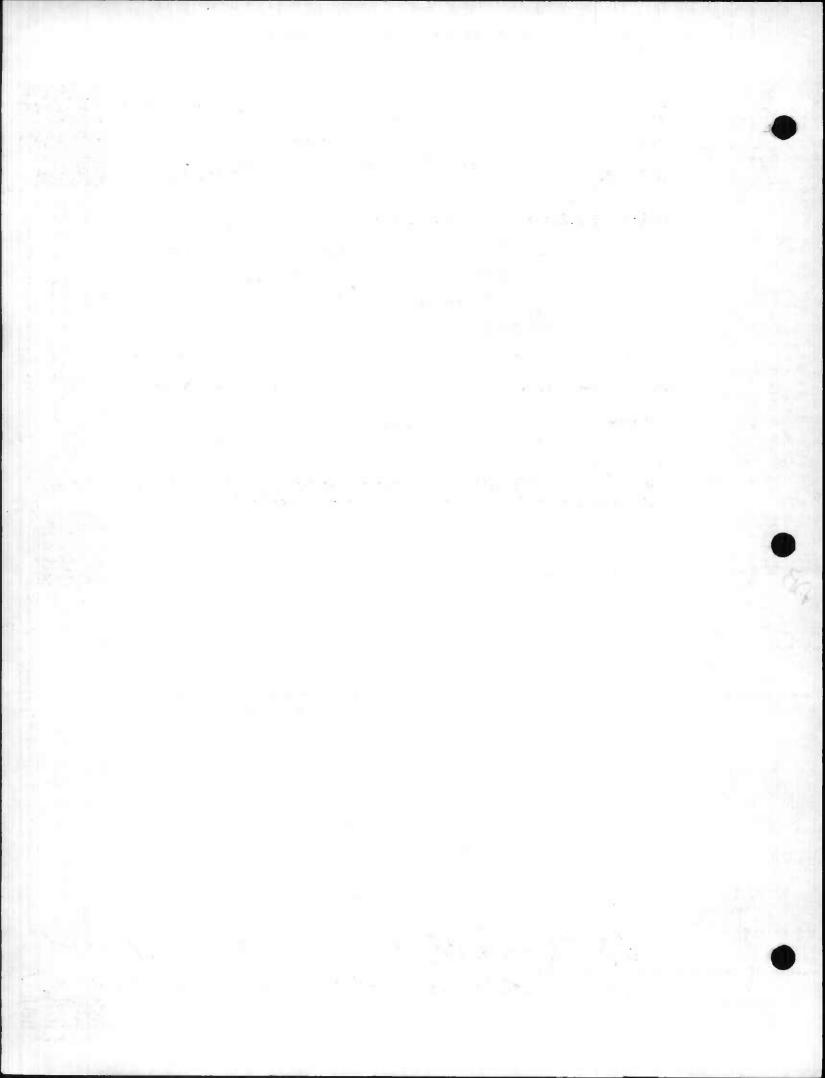
31. Dete filed (Month, Dey, Year) SEP 2

32. Registrar's Signature



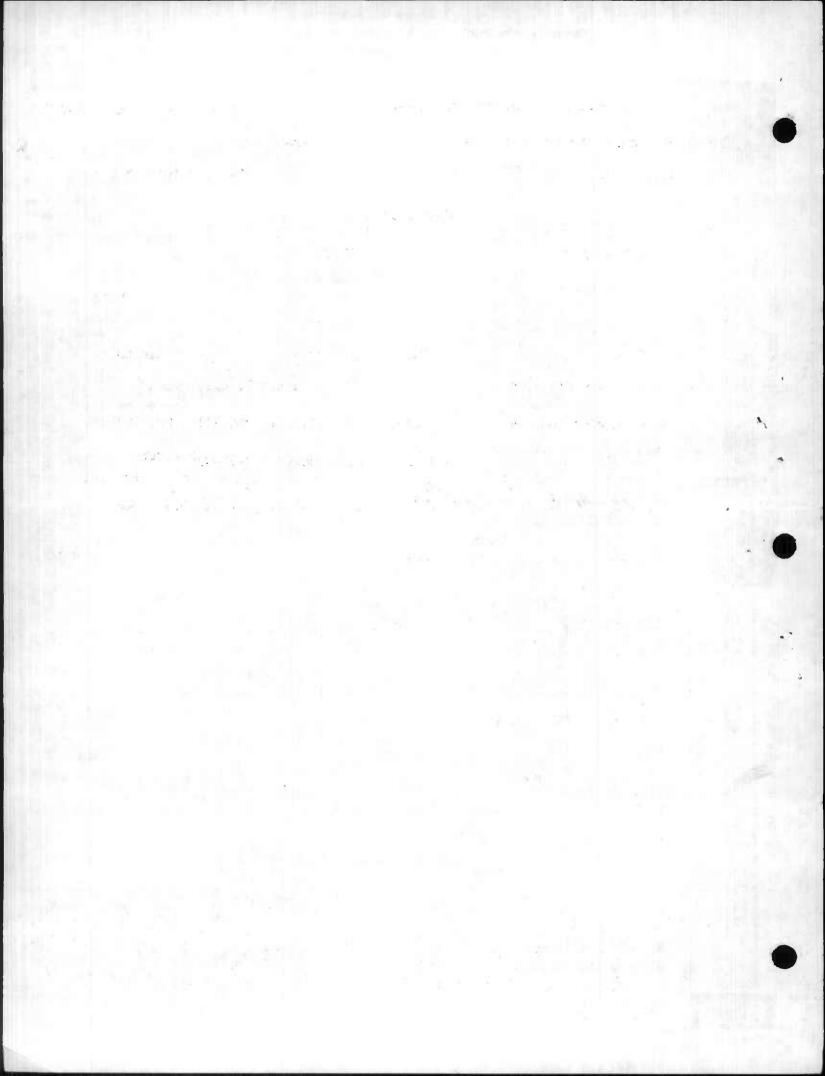
sician edical miner	1. Decedent's Neme (First, Middla, La					2. Dete of Dee	th	3. Tima of De	
edical	Three Envent					Month	15, 1998		
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	Genesis Elder				4%. City, Town, or Randallst			imore	
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ral tor		DXM 2□ F 72	Yrs.	Months Days	Hours Min.	8. Dete of Birth (Month, Day Sept.	28. 1925	Birthplaca (Stata or F Country) New Jerse	
	Usuel Rasidence of Decedent					осре.	20, 1723	New Gerse	
	10e. State 10b. County		c. City, Town or L					10d. Inside City L	
g	Maryland Baltim	ore	Randalls	town				1 ☐ Yas 2	
Director	10e. Street and Number	1		10f. Zip Coda	2		IOg. Citizen of Whe	et Country?	
	9109 Liberty Roa			2113					
Funeral	11. Marital Status	12. Wes Decedant Ever Armed Forces?	r in U,S. 13.	if Yes, specify Cu	Hispenic Origin? (S ban, Mexicen, Puar	o Ricen, etc.)		Amarican Indian, Whita, atc.	
by	1 Nevar Married 2 Married 3 Widowed 4 Divorced	1 ☑ Yas 2 ☐ No If Yes, Give Yaar or Dates: 19	44-46	1□Yes 25KNo	Specify:		Specify:	White	
	A STATE OF THE PARTY OF THE PAR			edent's Usuei Occu	pation		16b. Kind of Busin	ness/industry	
plet	(Specify only highest gra		(Giv	e kind of work don DO NOT use retir	during most of wo	rking		,	
Completed	Elamantary/Secondary (0-12)	Collega (1-4or 5+) 5+	u	ınknown			unknown		
Be C	17. Fethers Name (First, Middla, Last				18. Mother's Ner	ne (First, Middle,	Meiden Sumame)		
ToB	Eugene Weiss To	rrey		Helen Elizabeth Gosnell					
	19e. Informent's Neme/Reletionship (	Type, Print)	19b. Mell	ling Address (Stree	et end Number or Ru	ural Route Numbe	r, City or Town, Sta	ate, Zip Code)	
	unknown		unkr						
nry or r	20e. Method of Disposition  1 Durial 2 Crametion 3 D		20b. Plece of Disp cemetery, cre	oosition (Neme of emetory or other pl	ece)	Dete	20c. Location - Cit	y or Town, Stete	
	4 ☑ Donetion 5 ☐ Other (Special								
	21. Signature of Europal Service Lice Wade	Director	Ś	2. Nama and Add	ress of Facility Tomy Boar	d. 655 W	. Baltimo	ore Street	
	Varassens	11/ 1000	72		, Marylan				
Examiner	Sequentially list conditions,	b	o to (or es a conse						
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
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by P							20110 3		
Completed b						24a. Wes e perfor	en eutopsy 2 med?	24b. Were eutopsy find available prior to completion of caus of death?	
E						1 🗆 Y	es 2 🗆 No	1 ☐ Yes 2 ☐ No	
Be C	25. Was case referred to medical examiner?				28. Place of De	eth (Check only or	na)		
To	1 Yes 25 M5		2 ER/Outpatie	ent 3LI DOA		ioma 5□Resid	ence 6 Other	(Specify)	
	27. Manner of Death  1 Hatural 5 □ Pending	28e. Dete of Injury (Month, Dey Ye	28b. Time (Injury	W		28d. Describe h	ow injury occurred		
Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b		414		Yea 2□No	004 1	Manada — d Ad — d	on Dunel Double At and	
ŧ	4 Homicide detarmined	28e. Plece of Injury - building, etc. (S	At home, ferm, s Specify)	treet, factory, office		28f. Location (S City or Tow	n, State)	or Rural Route Number	
	29a. Certifier 15 Certifying Pr	ysician: To the best of m	v knowledge, dee	th occurred et the	time, dete end plece	a. and due to the c	ausa(s) and mann	ar es stated.	
edical		niner: On the basis of exa	aminetion and/or la						
×	29b. Signature and title of certifier		,	29c. Licar	nse number	2	29d. Dete signed (I	Month, Dey, Year)	
	> LM	11/1/28 0	M	1)	2033	3	8/	19/91	
	30. Name, and address of person who	completed cause of deeth	(frem 23a) (Type	p. Print)			/	rude m	
	ov. Hameyand address of person who								

DHMH 16 Rev 6/95



## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

. Item#4c	per Phy G763 9/21/98 EW	State of Marylar	Certifica:				Reg. No.	l'es	8122
Physician	1. Decedent's Neme (First, Middle, Last)		1:			2. Dete of Dec Month	Dey	Yeer	3. Time of Death
/Medical	Phillip  4e Fecility Name (If not institution, give s		lliamson		4b. City, Town, or L	Aug,	18, 19		3:30 P.M.
Examiner	Washington Advent				Takoma P		Montgo		
Funeral Director	5. Sociel Security Number 6. Sex 223–16–7705		last birthday) If Unde Months	r 1 Yeer Deys		8. Dete of Bird (Month, De Sept. 1	h y, Year)	,	lece (State or Foreign try) inia
the Maryland 2841 show norrise at	Usuat Residence of Decedent  10e. Stete 10b. County  MD		ty, Town or Location /attsville					11	0d. Inside City Limits 1X Yes 2 □ No
offer death with the Maryland r flores 23a or 28a-f show the must be not fled a Funeral Director	10e. Street end Number 1700 Dekalb Ct.			2078	2		10g. Citizen of W	het Coun	try?
P 22 P	11. Meritel Status  1 Never Merried ACKMerried  3 Widowed 4 Divorced	I2. Wes Decedent Ever in U Armed Forces? 1Y Yes 2 □ No If Yes, Give Yeer or Dates:	J,S. 13. Was Dece If Yes, spe 1 ☐ Yes		lispanic Origin? (Sp en, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		- Americ k, White, d Bla	
Maryland 21215-0020 The should be filed within 72 hours aff this and Mental Hygiens of 71 is marked other than "natural", or traumatic event, the Medical Example To Be Completed by R	15. Decedent's Educ (Specify only highest grede Elementary/Secondary (0-12)	cation com <i>pleted)</i> College (1-4or 5+)	16e. Decedent's Usu (Give kind of w life. DO NOT L	se retired	o)	ing	16b. Kind of Bu		lustry
iore, Maryland 2 ges 1 end's should be filed if to thealth and Mental Hygica to other traumatic event, #	12th 17. Fether's Neme (First, Middle, Last) Willie D. Willia	mson	Rail Car	ruspe	18. Mother's Nem				
Marylar end 2 should be saith and Menican 27 is merked or traumatic or	19a. Informant's Neme/Relationship (Type	pe, Print)	19b. Mailing Addres	s (Street	and Number or Run	rai Route Numbe	er, City or Town,	State, Zip	Code)
re, Mary 1 end 2 sho Health and 1 em 27 is me other treum	James Hunter (ne		1700 Dek		Ct., Hyat	T			
	20e. Method of Disposition  1 XBuriel 2 Cremetion 3 R 4 Donetion 5 Other (Specify)	emovel from Stete	ew Free Spr	ing (	Church		Rustburg		
Baltin's permit. Per Department Importants Importants English	21. Signature of Funeral Service License	111.	1//		91	8 Fifth	St.		н.
Physician /Medical Examiner	23a. Pert1. Enter the diseese, or complishock, or heart failure. List only or Immediate Ceuse (Finel disease or condition resulting in deeth)	Sep	S S or as a consequence of		ng, such es carolac	or respiretory a	rest.	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Approximate Intervel Between Onset end Death
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Box 68 ath certifical attending ph for use as th	resulting In death) Lest								
- op op	Pert II. Other algnificant conditions con	tributing to death but not re-	sulting in the underlying	cause giv	ren in Pert I.	23b. Dld	tobacco use con	tribute to	the cause of death?
Is, P.O se that the igned by the be deteched	liver ter	lure				1 🗆	Yes 2□ No	3 ☐ Prot	bably 4页Unknown
s been s 2 should							en autopsy rmed?	eve	ere eutopsy findings elteble prior to mpletion of cause death?
Vital Recentificate he rector, page						10		1[	Yes 2 No
Of Vita Physician: this certific ral director,	25. Was case referred to medical exeminer?  1 Yes 2 No	lospitel:	ER/Outpetient 3□ D	OA Oth	26. Place of Dea		one) dence 6 ⊡Othe	er (Specifi	v)
Vision of Attending Phys of Geath. ector: After this by the funeral di	27. Manner of Death  1 1 Neturel 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Dey Year)		28c. Injui Wo			how injury occurr		"
Division C To the Hospital or Attending P within 24 hours elter death. To the Funeral Director: Aher th completely filled in by the funera Medical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plece of Injury - At h building, etc. (Speci	nome, farm, street, fecto	ry, office		28f. Location ( City or To	Street and Numb wn, State)	er or Rura	l Route Number,
he Hospi in 24 hou he Funer pletely fill edical		licien: To the best of my knower: On the basis of examination							
To the Com	29b. Signature end/title of cartiles	le Sigh	M) 25	D. Licens	15660		8-19	(Month,	Day, Year)
	30. Name and address of person who co	mpleted cause of deeth (Ite	m 23a) (Type, Print)	( (	W,	BOL	sie r	10	20711
State Registrar	31. Dete filed (Month, Day, Year)	32. Registrer's Sign	ature &	Loan	KS				



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth September 11,1998 **Physician** 9:20 AM J. Robert /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Anne Arundel Crofton Convalescent & Rehab Center Crofton If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year) NOV. 5, 1937 9. Birthplace (State or Foreign Country) V1rg1n1a 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 60 Yrs. Director 229-48-8681 Usuai Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show 1 Yes 2 No Directo Maryland Anne Arundel Crofton 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 21114 USA 2131 Davidsonville, Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Department of Hamilton and American Control of the Control of Hamilton and Mental Hygiana. Importment if them 27 is marked other than "natural", or ther my injury or other traumaths event 1 Never Married 2 Married Specify: Black 1 Yes 2 No Specify: À 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Roofer Construction 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be George Wells 2 Pauline Morris 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 315 Mountain Road, Pasadena, MD 21122 Betty Anne Bach - friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 20e. Method of Disposition Wayland Baptist Church Cem 1 ■ Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Louisa Virginia 22. Name end Address of Fecility 21. Signature of Funeral Service Ligensee Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part f. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line! Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Dia leter 10 years physician and the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Due to (or as a consequence of): 50 usa Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Demention Completed by 24b. Were autopsy findings aveilable prior to 24a. Was en eutopsy performed? completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 No cartificate 25. Wes case referred to medical exeminer? 1 ☐ Yes 2 ☒ No diractor. Be 26. Piace of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To funeral 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Funeral

law requires that the death certificate be axecuted Records, P.O. s after death.

I Director: After this cartifical

death with the Maryland

altimore, Maryland 21215-0020

Division of Vital Hospital To the Hosp within 24 ho To the Fune complately f

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature end title of saudifinit

29c. License number

1 🔯 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted.

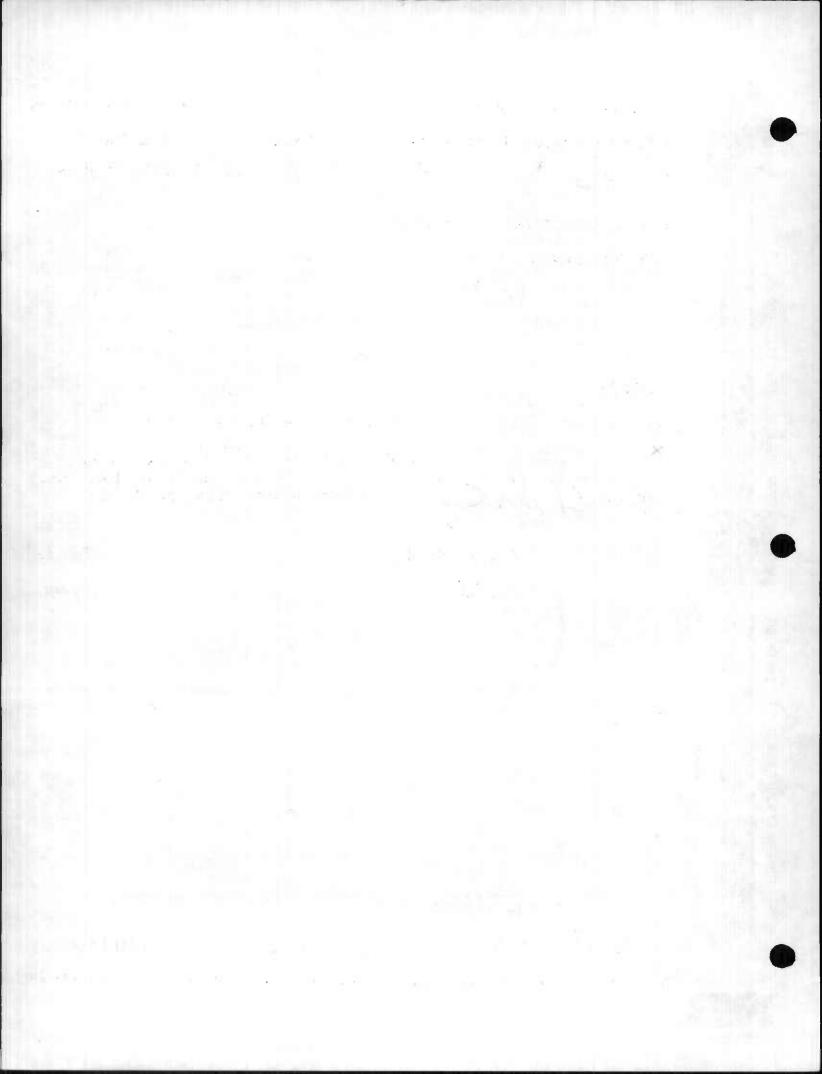
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

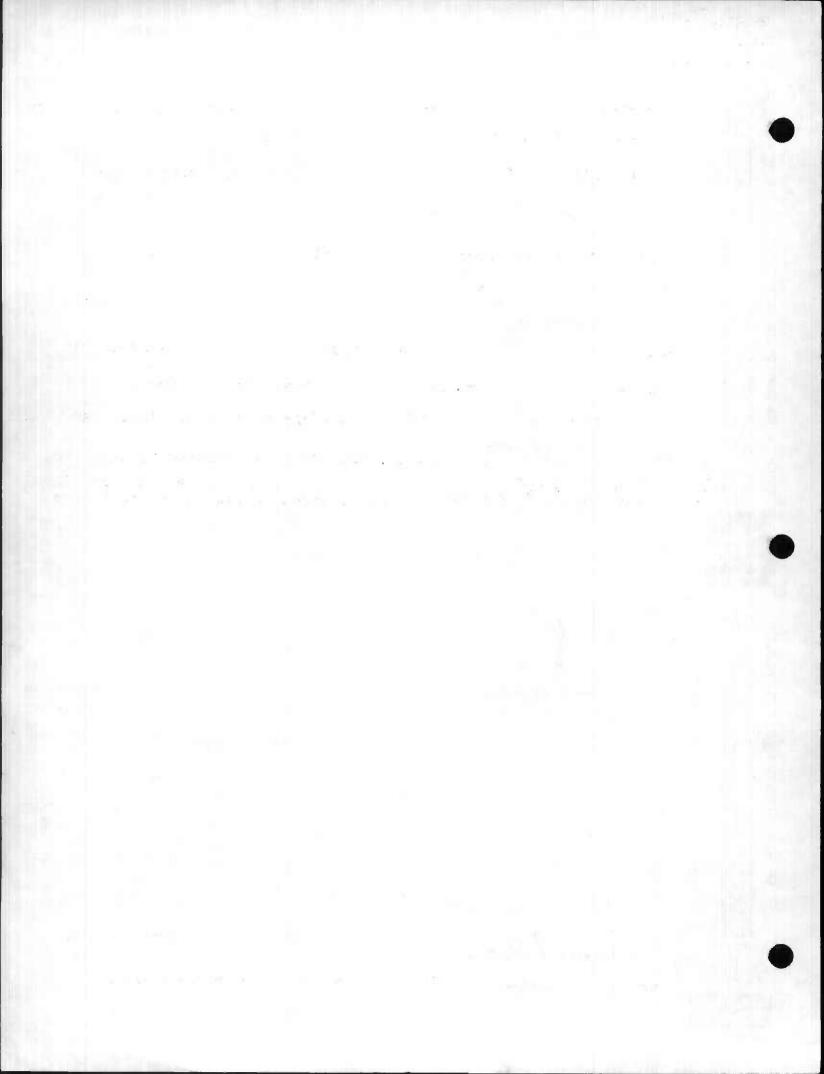
ANNAPOLIS ROAD #106 ODENTON MD21113 1413

SINGH SIDHU DALJEET 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP



	K.S		Please	Type or Pri State of M					Assure Alealth and N			ible.	3724	
PA	MELA WALK	ER ITEMS:	#23 PART I,	27 PER MEO	G763	9-24-98 Cei	tificate	of L	Death		Reg. No.		)   C, "Y	
F	Physician	1. Decedent's Nen Pame	ne (First, Middle, Las La	on)	Wa	alker				2. Dete of De Month SEPT	Dey	Yeer 998	3. Time of Dec	
1	/Medical Examiner	4e Fecility Neme (	If not institution, give	street end number,	)			41	b. City, Town, or L		h 4c. Coun	ty of Deeth		
		604 NO	RTH DUKELA	AND STREET	Γ				BALTIMO		N	A		
	Funeral Director	5. Social Security 1 216-76	-8953 <sup>1</sup>	9X 7. Ag	ge (In yrs. I	est birthdey) Yrs.	If Under 1 Y	eys	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Di		9. Birthple Countr	ce (Stete or Fo y)	reign
	D	Usuei Residenca d	10b. County		10c. City	, Town or Lo	cation					10	d. Inside City Li	mits
	fatho sed at	Md	NA			Ltimo							1X Yes 2	
	128s notifi	10e. Street end Nu	ımber				10f. Zip Co	ode	_		10g. Citlzen of	Whet Countr	y?	
	38 out	2623 W	. Coldsp	ring La	ne		212	215	5		USA			
0	aura after death with the Manyla nat, or litera 23e or 28e-f sho Examiner must be notified at by Funeral Director	11. Marital Status	ried 2 Married	12. Wes Decedent Armed Forces 1 Tes 22 If Yes, Give	Ever in U,		Wes Decedent f Yes, specify		spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	5- 14. Re Bi	ace - America eck, White, e	c.	
00	72 hours after natural, or its fical Examina sted by Fu	3 Widowed		Yeer or Detes:								ВТа		
21215-0020	be fled within 72 ho tal Hygiene. d other than "naturn event, the Medical I Be Completed	(Spe	15. Decedent's Ed cify only highest gra	ucation de completed)		16e. Deced (Give	dent's Usuei C kind of work of DO NOT use r	ocupa done d	ation <i>luring</i> most of work )	ring	16b. Kind of	Business/Indu	stry	
12	the Man	9th Gr	ondary (0-12) ade	College (1-4or	5+)		mploye		<b>,</b>		Neve	r Wor	ked	
D	of the control of the	17. Father's Neme	(First, Middle, Last)					T	18. Mother's Nem	e (First, Middle	, Maiden Surna	me)		
lan		Alle	n	1	Walke	er			Rose 1	Mary	Boon	e		
Maryland	s marks and Men s marks aumatic	19a. Informent's N	lame/Reletionship (7	Type, Print)					and Number or Rui					
Σ,	and sallh	Joann	Boone						dspring					121
Baltimore,	of the state	20e. Mathod of Dis	position  Cremetion 3	Removal from State	CE	emetery, crer	sition (Neme metory or otha	rplec		Dete		- City or Tov		
Ë	E 8 2 1	4 La Constion	5 ☐ Other (Specify		Vo				Gardens	09-22	-98 Du	indalk	, Md.	
Bal	Department of Important: If important: If any injury or affice.	21. Signature of F	unerei Service Licen	06/	ro		2. Name end A		Ba		re, Ma			02
	Physician /Medical Examiner	23a. Pert1. Enter shock, or had Immediate Ceuse disease or condition resulting in daath)	on		\CQU <b>I</b> RE	n. Do not eni	er the mode o	of dying	arch FH g, such es cardiec Y SYNDROME			- 7-15	Approximate Interval Betwee Onset and Deal	
0,	e executed in and unal-trensit	Sequantially list coif eny, leeding to it cause. Enter Und	erlying	b	Due to (or	r es e consec	quence of):							
P.O. Box 6876	The law requires that the death certificate be the has been signed by the ettending physicial page 2 should be deteched for use as the but completed by Physician/Medical	that initieted event resulting in death)	S	d	Due to (or	es e conseq	uence ot):							
Ď.	d for	Pert II. Other sland	ficant conditions of	ontributing to death i	but not resu	ulting in the u	nderiving ceus	se give	en in Pert I.	23b. Dio	tobacco use o	contribute to	the cause of d	eath?
	igned by the be deteche by Phys									1□	Yes 2□ No	3 □ Prob	ably Uni	cnown
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours efter death. To the Funeral Director: After this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be deteched for use Medical Certification: To Be Completed by Physician/M										s en eutopsy ormed?	eve	ra eutopsy tindi ileble prior to apletion of caus eath?	5
<u> </u>	The page									1 🗆	Yes 200	10	Yes 2□ No	
/ita	elan: ertific ector,	25. Wes case rata exeminer?	rred to medical					Lou	26. Plece of Dae					
on of	fing Physician:  After this certific funeral director, tion: To Be	1 Nenner of Dee 1 Natural		Hospitel: 1 Inpati	urv	ER/Outpetier 28b. Time of Injury		Othe	4 🗆 Ruising D		how Injury occ		AT SCE	NE
Divisi	To the Hospital or Attending P within 24 hours efter death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homlcide	6 Could not be detarmined	28e. Piece of in	jury - At he	ome, ferm, str	reet, factory, o	office			(Street end Nur own, State)	mber or Rurel	Route Number	,
	ne Hospita ne Funera pletely fille edical (	29a. Certifier (Check only one)	1☐ Certifying Ph 2∰Medicat Exam	ysician: To the bast niner: On the basis of and manner s	ot exeminat	wledga, daatl ion and/or in	h occurred et l vastigation, in	the tim	ne, dete end place pinion, deeth occur	and due to the red et tha tima	ceusa(s) and , deta end plec	mannar as sto e, end dua to	itad. tha causa(s)	
	To the comp	29b. Signature en	Hitla of certifier	1. Chuten	P				e number 29d. Date signed (Month, Day, Year) .M.E SEPT. 15, 1998					
_		30. Nama end edd	rass of person who	completed cause of	11	1 Penr		et,	Baltimo	re, Mar	yland 2	1201		
	State Registrar	31. Dete filed (Mon	SEP 2	1 1998 Negist	rera Signa	ture	B. ,	do	als					

DHMH 16 Rev 6/95



### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day 935 Marion Elizabeth Walker September 15, 1998 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Chesapeake Hospice House Linthicum Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 M 2 F Months Days Hours 217-24-1285 70 Yrs. May 28, 1928 Md. Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits Anne Arundel Glen Burnie 1 Yes 20 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 7900 Benesch Circle Apt. 768 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Merried 1□ Yes 2□No Specify: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) National Security Elementery/Secondery (0-12) College (1-4or 5+) Administrative Service Agency 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Ernest Sewell Annie Harris 19a. Informant's Name/Relationship (Type, Print) SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George T. Walker 7864 Golden Pine Circle Severn, Md. 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Sept. 21 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Veterans Cem. 21. Signature of Funeral Service by 22. Name and Address of Fecility Nutter Funeral Homes, Inc. Em 2501 Gwynns Falls PKWY Baltimore, Md. 23a. Part f. Enter the disease, or complications that daused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Nonsmall coll disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequenca of): Due to (or as a consequence of):

**Physician** /Medicai Examiner

**Physician** 

/Medical

Examiner

Md.

Director

Funeral

by

Completed

**Funeral** 

Director

7 is marked other than "naturel", or itema 23s or 28s-f show traumatic event, the Madical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or itema 23a any injury or other traumatic event, the Men

with the Maryland

Examiner Physician/Medicai by Completed 25. Was case referred to medical examiner? Be 2 27. Manner of Death Certification:

1 Yes 2 No

5 Pending

investigation

6 Could not be determined

1 Neturel

2 Accident

3 Suicide

29a. Certifie

4 - Homicide

31. Date filed (Month, Day, Year) SEP 2 1 1998

attending physician and for use as the buriai-transit the signed by to peen has has page 2 certificata director. this funerai After To the Hospital or within 24 hours after death.
To the Funeral Director: Aft

The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

Hospital or Attending Physician:

To

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

24a. Was an autopsy performed? 26. Place of Death (Check only one) Marient 2 ER/Outpatient 3 DOA

28e. Date of Injury (Month, Day Year) 28b. Time of 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how Injury occurred 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 No

1 Certifying Phyalcian: To the best of niy knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end menner stated. (Check only one)

29d. Date signed (Month, Day, Year)

1 Yes

29c. License number 29b. Signature and title of certifier 337-48-8579

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to

completion of cause of death?

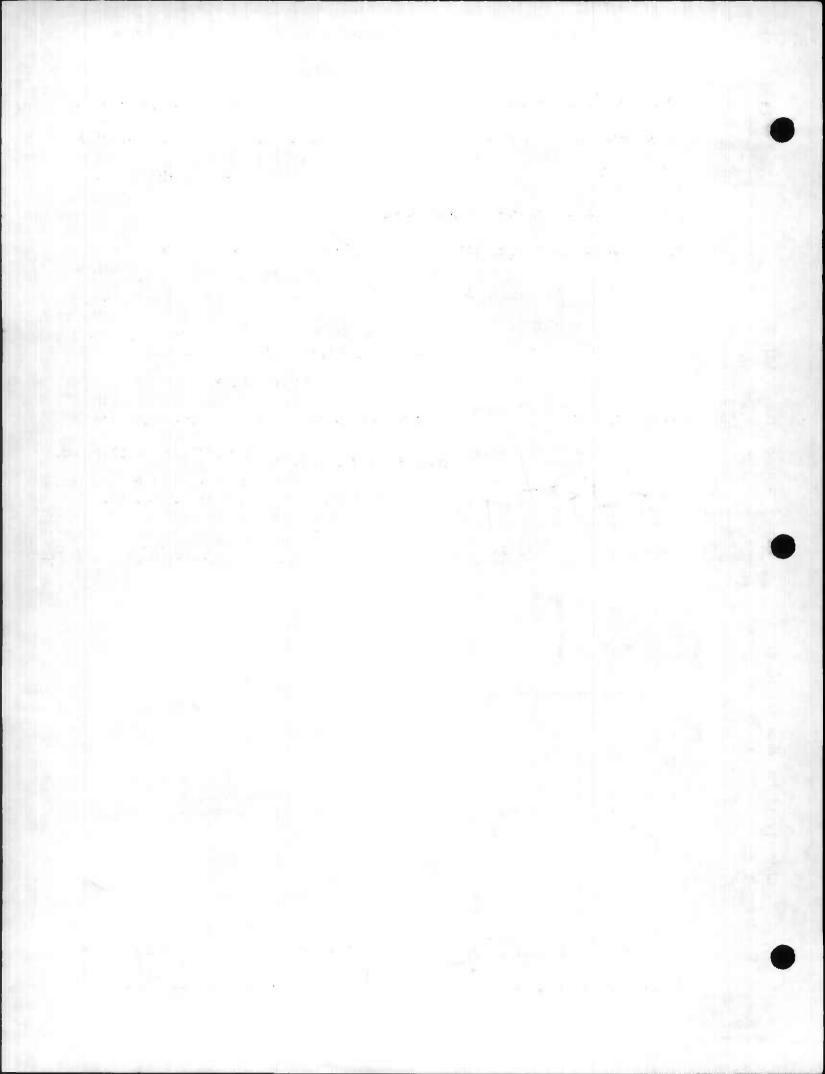
1 Yes 2 No

30. Name and eddress of person who com leted cause of death (Item 23a) (Type, Print) Anderes Walter Reed M.

ermy Medical Center 32. Registrar's Signature

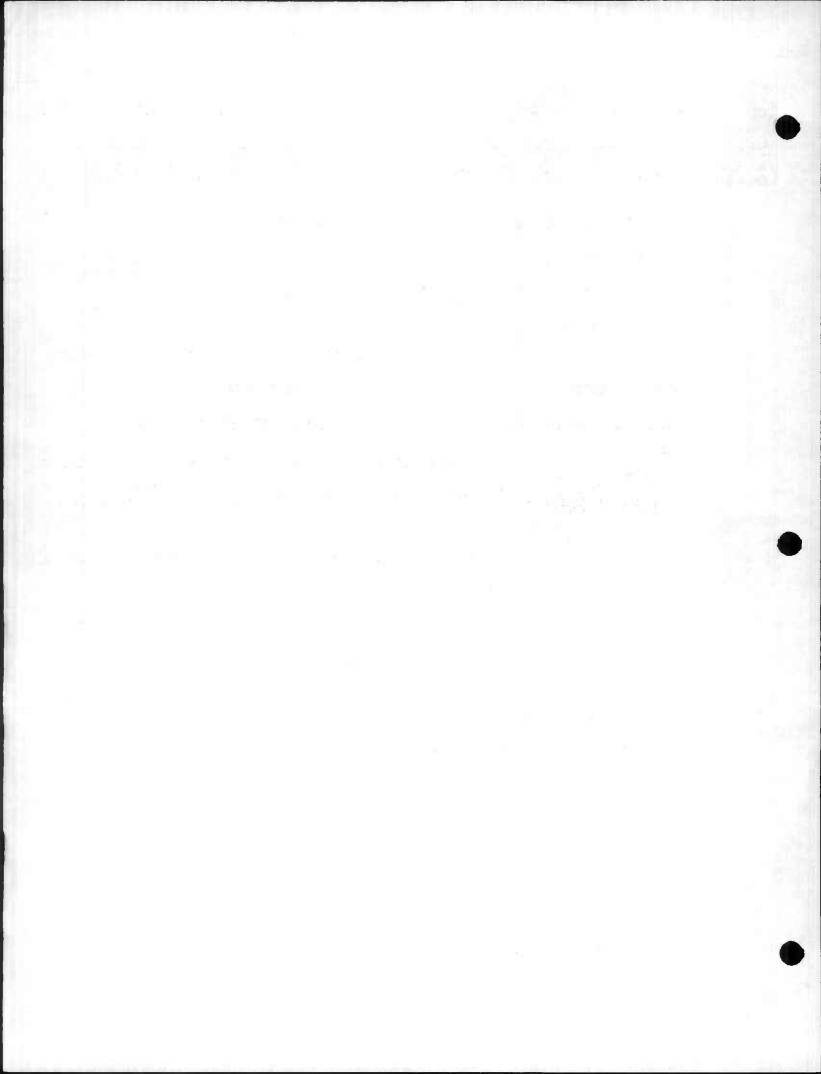
State Registrar

edicai



State of Maryland / Department of Health and Mental Hygiene 98 2972

			1 Decodorate Name (First Middle				tificate of	Death		Reg. No.	1 6	1120
	Physic	ian	Decedent's Neme (First, Middle,     Decedent's Neme (First, Middle,						2. Dete of De Month	Dey	Year	3. Time of Death
	/Medi		JESSE ALLEN	ALGER					AUGUST		998	6:50 AM
	Exami	ner	4e. Fecility Neme (If not institution,					4b. City, Town, or		,		
			AVALON MANOR NU. 5. Social Security Number 6			6245 4 1	If Under 1 Year	HAGERS If Under 24 Hrs			SHINGT	
	Funeral Director		235-28-3021 Usuel Residence of Decedent	1⊠ M 2□ F	ge (In yrs. lest 77	Yrs.	Months Deys	Hours Min.		v. Year)	9. Birthpla Country WEST	CS (State or Foreign VIRGINIA
	and		10e. Stete 10b. County		10c. City, T	own or Loc	cation				100	d. Inside City Limits
	with the Meryland a or 28a-f show	ō	MARYLAND WASH	INGTON				SAPLAND				1 ☐ Yes 2 No
	the 288	Director	10e. Street end Number	TINGTON			10f. Zip Code	APLAND		10g. Citizen of \	What Countr	w2
	23a or		3214 GAPLAND RO	A.D.			10.1.2.0	21770		-		,,
	leath Tre 2:	Funeral	11, Maritai Status	12. Wes Decedent	Ever in U.S.	13. V	Vas Decedent of I	21779 dispenic Origin? (S			S.A.	n Indien
2-0020	hours efter death with the Meryland turst, or items 23a or 28s-f show at Examiner must be notified at	by Fur	1 ☐ Never Married 2 Ă Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?	,	-	Yes, specify Cub	dispenic Origin? (S an, Mexican, Puerl Specify:	o Rican, etc.)	Specify	ck, White, et	te.
5	72 hours netural,	Pe	15. Decedent's	Education		6a. Deced	ent's Usuel Occup	petion		16b. Kind of B		
7	within 72 ene. than "nat	Completed	(Specify only highest g Elementary/Secondery (0-12)	college (1-4or	54)	(Give I	kind of work done OO NOT use retire	petion during most of word)	rking			
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ylan		2	HUBERT ALGER					LORA BU	RNER			
Mar	d 2 should th end Mer 7 is marke traumatic		19a. Informent's Neme/Reletionship	(Type, Print)	1	19b. Mailin	g Address (Street	end Number or Ru	ural Route Numbe	er, City or Town,	Stete, Zip C	(ode)
2	C = 0 -		REGINA E. ALGER	/SPOUSE		3214	GAPLAND	ROAD, GA	PLAND, M	IARYLAND	2177	79
ore	ges 1 en it of Haal if Item 2 or other		20e. Method of Disposition 1 X Burial 2 ☐ Cremetion 3	□Removel from State	0.000.0	of Dispos etery, crem	sition (Neme of netory or other ple	ce)	Dete	20c. Location -	City or Tow	n, Stete
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Saltimor	permit. Pag Depertment Important: I any injury o		21. Signature of Funeral Service Cit			22.	. Name end Addre	ess of Facility	7606 010			
D	805 8 8		10-16h	Paul	M. Dea	n BAS	ST FUNER	AL HOME	Boonsbor			21713
			23e. Pe 11. Enter the disease, or co shock, or heart feilure. List on	mplications that cause	d the death. D	o not ente	er the mode of dyi	ng, such es cerdia				Approximete
	Physician		SHOCK, OF HEAR TENDER. LIST OF	y one ceuse on each ii	me.							ntervel Between Onset end Deeth
	/Medical	П	Immediate Cause (Final disease or condition	Ant	7.0	nder	T. C	andinas		ala e		14
	Examiner		resulting in death)	е	Due to (or es				and b	- Commander		~
-	D #	Examiner		. AL		ibnil					1	7
	ecute	am	Sequentially list conditions,	D	Due to (or es							
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X D	v requires thet the death cer been signed by the ettendir should be detached for use	Physician/		d								
	e de the e	/sic	Pert II. Other significant conditions	contributing to death b	ut not resultin	g in the un	derlying ceuse gi	ven in Pert I.	23b. Dld 1	obacco use co	ntribute to t	he cause of death?
	d by the	Phy	Carrisma. 1	inter 1	6,10	450	e.	Dain 4	10	Yes 2 No	3 Proba	ibly 4 <del>☐Unknown</del>
S.	igne bed	by						anun				
cords,	requires that	Completed	Hopethrailin	Horen	Litte	0	with a	rellist.	24e. Wes perfo	en eutopsy rmed?	eveil	e eutopsy findings leble prior to
D	law las b	npie									of de	pletion of ceuse eath?
=	Attending Physician: The law sr deeth. ector: After this cartificate has by the funeral director, page 2	S							101	fes 2□No	10	Yes 2□ No
7112	Attending Physician: or deeth. ector: After this cartific by the funeral director,	Be	25. Wes cese referred to medical exeminer?						ath (Check only o	ne)		
5	hysic his c	P	1 Yes 2 No		ent 2 ER/	Outpetient	SU DON		lome 5 Resid	tence 6 □Oth	er (Specify)	
=	frer the	on:	27. Menner of Deeth 1 ☑ Naturel 5 ☐ Pending	28e. Date of Inju (Month, Da	y Year) 28t	b. Time of fnjury	28c. Inju	ry et rk?	28d. Describe h	now injury occur	red	
200	eeth.	cati	2 Accident investigate 3 Sulcide 6 Could not				M 1	Yes 2 □ No				
DIVISION	frer d frect frect in by	Certification:	4 Homicide determine	d 289. Place of Inj	ury - At home, c. (Specify)	, ferm, stre	et, factory, office		28f. Location (5 City or Tox	Street end Numb vn, Stete)	er or Rural I	Poute Number,
3	urs a											
	To the Hospital or Attending F within 24 hours after deeth. To the Funeral Director: After complataly filled in by the funer	edicai	29e. Certifier 1 ☐ Certifying F (Check only one) 2 ☐ Medical Ext	Physician: To the best of eminer: On the basis of end manner sta	f examination	ige, deeth end/or invi	occurred et the til estigation, in my o	me, date end plece ppinlon, deeth occu	, end due to the rred at the time,	ceuse(s) end me date end place.	nner es stet end due to t	ied. he ceuse(s)
	To t Com	Σ								29d. Date signe	d (Month, Da	sy, Year)
			<b>─</b> (टा	the mo			510	9019		Ang 3	1. (59	8
			30. Name end eddress of person wh	completed cause of d	leath (Item 23)	a) (Type, F	grint)	0.0	A			-
			Vasant Datt	a 334 r	nill S	7.	Hacerst	own, M	0 217	40		
	Sta	te	31. Dete filed (Month, Day, Year)		er's Signeture	4				,		
	Registr	ar	AUG 3 1 1	998		1.	poork	2				



Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 28727

				Certi	ficate of	Death		Reg. No.		T had T
	1. Decedent's Nama (First, Middle,	Last)					2. Date of Dea	ath Day	Year 3	3. Time of Death
Physician /Medical	DORIS	DUBC	IS	7 ± 13	BALSTER		Augus		998	9:50 PM
Examiner	4a Facility Name (If not institution,					4b. City, Town,	or Location of Death			
	7690 Old Mill R	d				Willa	rds	Wi	icomico	2
uneral		. Sax 7. A	ga (In yrs. la	age Directionary	If Undar 1 Yaar Months Days	If Under 24 I	Irs. 8. Date of Birt	h		e (Stata or Foreign
rector	140-20-8065	1□ M 2⊠F	70	Yrs.	vioritiis Days	FIOUIS		15,1927		
rd at	Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Loca	tion			·	104	Inside City Limits
ral Director		mico		Willard						1 ☐ Yes 2 ☐ No
Director	_	XIIICO		WITTAL						
2 5	10e. Street and Number				10f. Zip Code			10g. Citizen of V	vnat Country	r
gra	7690 Old Mill		. C i. 11 C	10 1/4		374	VSanait. Van an Na	USA	e - Amarican	fadian
by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1	? ] No		es, specify Cub		(Specify Yas or No- uarto Rican, atc.)	Blac	ck, White, etc.	
eted	15. Decedant's (Specify only highest	Education		16a. Deceder	nt's Usual Occup	pation during most of	working	16b. Kind of Bu	usiness/Indust	try
Completed	Elementary/Secondary (0-12)	College (1-4o	5+)		nd of work dona NOT use retire			0-11		
Con	12	2		LIDIA	ibrary Coordinator College  18. Mother's Name (First, Middle, Maiden Sumame)					
To Be Comp	17. Father's Name (First, Middle, La	st)				18. Mother's I	Name (First, Middle,	Maiden Sumam	10)	
၉	Emerson DuBoi	S				Flore	ence E. Ve	echan		
	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing	Address (Street	and Number of	r Rural Route Numbe	er, City or Town,	State, Zip Co	ide)
	Carl W. Balste	r/Husband				ll Rd.,	Willards			
	20a. Method of Disposition  1		Ce		ion (Name of tory or other pla Grove Ce		9/3/98	Elmer,		, State
detached for use as the buriel-transit  Dhysician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequantially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury that initiated events resulting in death) Last	a. CRUI b. IN Sc c.	Due to (or	as a conseque as a conseque as a conseque	nce of):	CLRSG DIAP	SHOSIS SETTES N	S newr	2	
ed for	Parl II. Other significant conditions	contributing to death	but not resul	Iting in the und	erlying ceuse gir	ven in Part I.	23b. Dld	lobacco use co	ntribute to the	e cause of death?
by Physician/M							10	Yes 2□No	3 Probab	Unknown
Completed by P							24a. Was perfo	an autopsy rmed?	availa	autopsy findings able prior to lefion of ceusa ath?
EO							10	Yas 2 No	1 🗆 Y	'es 2□ No
Be	25. Was cese referred to medical examiner?					26. Place of	Death (Check only o	one)		
10	1 Yes 2 No	Hospital: 1 🗆 Inpa	tient 2 E	ER/Outpatient	3□ DOA Oth	har: 4 Nursin	ng Home 5 Resid	dence 6 □Oth	ner (Specify)	
ation:	27. Manper of Death 1 Anatural 5 Pending 2 Accident investigat		jury lay Year)	28b. Time of Injury	M 1	ryat rk? ∣Yes 2 □ No	28d. Describe	how Injury occur	red	
Certification:	3 ☐ Suicide 6 ☐ Could no determine		28f. Location ( City or To	Street and Numb vn, State)	ber or Rural R	oute Number,				
edical		Physician: To the bes aminer: On the basis and manner:								
complately filled in by tha funaral director, page Medical Certification: To Be Com	29b. Signafura and fittle of certifier 29c. Licansa number							29d. Data signad (Month, Day, Year)		
	190000	M/ 1			9/2	198				
10	30. Name and address of person wh	o completed course of	death floor	23a) (Tuna Da	int)	CLOOL		11-0	1 60	
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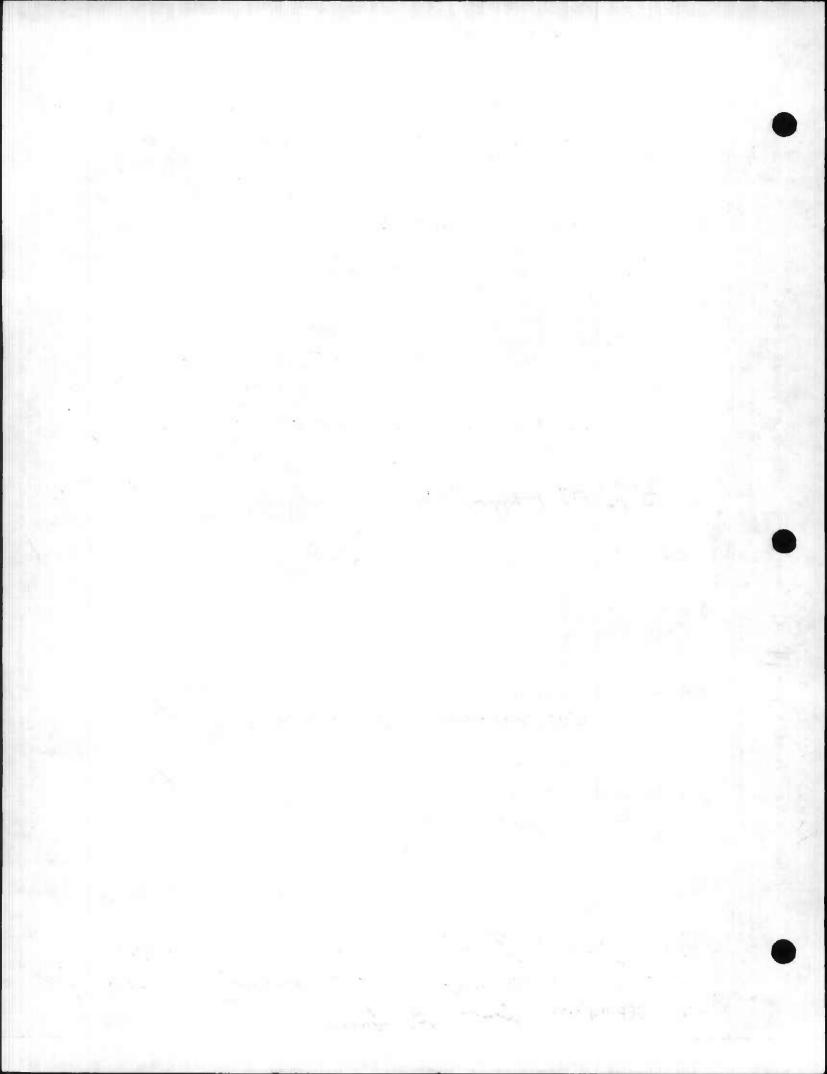
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Day 3, 1998 Physician 1105 BEAUCHAMP ELIZABETH /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBURY PENINSULA REGIONAL MEDICAL CENTER WICOMICO If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 10 M 2K) F Director SEPT. 7, 1920 MARYLAND 220-03-4147 Usual Residence of Decedent 10b. County r 28a-f show a notified at 10a. Stata 10c. City. Town or Location 10d. Inside City Limits N☐ Yes 2☐ No Directo MARYLAND WICOMICO PITTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b heme 23a BOX 247 21850 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indien, Bleck, White, etc. 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried "natural", or Saltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: g 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hyglene. other then "n Elementary/Secondary (0-12) College (1-4or 5+) 10 CHILDCARE/NANNY SELF-EMPLOYED permit. Pages 1 and 2 should be file Department of Heath and Mental Hy important: if flem 27 is merited oths any injury or other treuments 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be LESLIE TAPMAN ELIZABETH RICHARDSON F. 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) CHARLES E. BEAUCHAMP - HUSBAND BOX 247 PITTSVILLE, MARYLAND 21850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1998 1 N Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PITTSVILLE CEMETERY SEPT.6 PITTSVILLE, MARYLAND 22. Name end Address of Fecility 21. Someture of Funeral Service Licenses 705 E. MAIN ST. 21804 CFSP BOUNDS FUNERAL HOME, INC. SALISBURY, MARYLAND 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Betw **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical weed Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? page 2 should be detached 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy lindings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Be Completed 3 No 1 Yes 1 TYes 2 No or Attending Physician: director 25. Was cese referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospitel: Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To Division of 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation eral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner stated.

| Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D36576 muss of person who completed cause of death (ttem 23a) (Type, Print) 560 Ruerreale Dr. Saludy ME RONALD TRAVITZ MO 31. Date filed (Month, Day, Year) SEP 0 4 1998 32 Registrar's Signature

Registrar

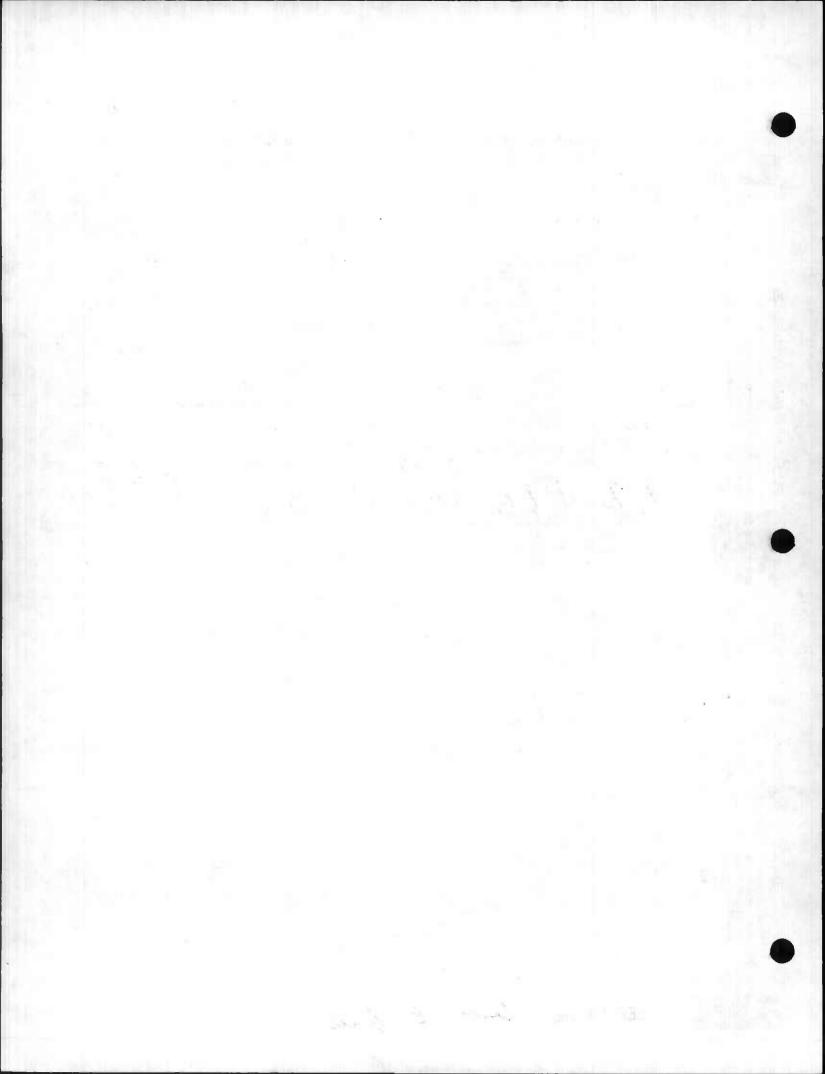
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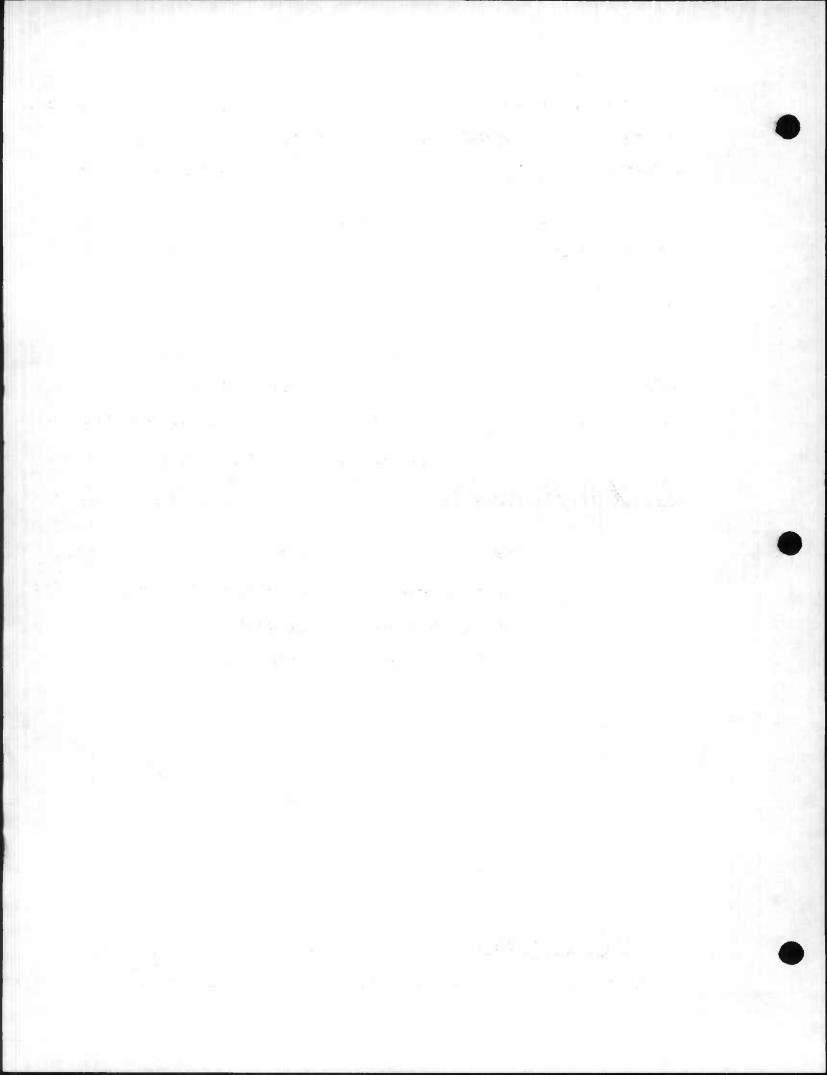
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Suptember 8 1998 **Physician** 094 CHARLES BREWINGTON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner PENINSULA REGIONAL MEDICAL CENTER 7. Age (In yrs. last birthday) | 1 Under 1 Year | 1 Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Yrs. | Wonths | Days | Hours | Min. | JULY 24, 1916 SALISBURY WICOMICO Birthplece (State or Foreign Country) **Funeral** Sex 1∭ M 2□ F Director MARYLAND 214-10-9468 Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow 1 Yes 2 □ No Director MARYLAND WICOMICO SALISBURY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23s or solical Examiner must be 711 ROGER STREET U.S.A. 21804 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1K) Yes 2 No WWII
If Yes, Give
Year or Detes: ARMY 1 Never Merried 2 Married 1 Yes 2♥ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filled within 72 hound of Health and Mentel Hygiene.
Int: If Nem 27 is marked other than "naturary or other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) MANAGER MOVIE THEATER 8 Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WILLIAM BREWINGTON Κ. GERTRUDE 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) C. RONALD BREWINGTON - SON 14512 CHRISMAN HILL DR. BOYDS, MD. 20841 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1X Burial 2 Cremation 3 Removel from State Department of Important: If eny injury or pance. 4 ☐ Donation 5 ☐ Other (Specify) 9-11-98 SALISBURY, MARYLAND WICOMICO MEMORIAL PARK 22. Name and Address of Fecility 705 E. MAIN ST. SALISBURY, MD. 21804 OF SA BOUNDS FUNERAL HOME, INC. 23a. Pert1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Onset end Death Physician Less Man Immediate Cause (Finel disease or condition resulting in death) /Medical 5 Judden Cardiac Death 24 hour Examiner Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No. 3 Probably 4 Unknown Lorge Grandla- hymphogy to Syndrone 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Wes case referred to medical examiner? 88 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 28€No 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Affer or Attending 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide To the Hospital o within 24 hours at To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner at align. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number Sept. 8, 1996 030690 ass of person who completed cause of deeth (Item 23a) (Type, Print) E. Grall St., 5.1360mg. MD. E. M.O. 145 25 31. Date filed (Month, Day, Year) 32 Registrar's Signature SEP 0 9 1998 Registrar Spark



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		Sarah Katherine 1  1. Decedent's Name (First, Middle, Lesi		Cei	tificate	of Death		eg. No.	2 4.0 / 3	U
Physic		0 -	Beneo.				2. Date of Dear Month	Day	Yeer 8.5	0 Dm
/Medi Examii		4e. Fecility Neme (If not institution, give Western Maryland	street and number)	Center		4b. City, Town, or Hagerstow		4c. County	14	-
Funeral Director		5. Social Security Number 218-38-1156 6. Se	х Эм 2 Б F 70	n yrs. lest birthday) Yrs.	If Under 1 Months	Year If Under 24 Hrs Days Hours Min.	B. Date of Birth	, 1928	9. Birthplace (State or Maryland	<i>Foreig</i> n
tand w		Usual Residence of Decedent  10a. Slate 10b. County	10	c. City, Town or Lo	cation		*		10d. Inside City	y Limits
the Marylar 28a-f show	ctor	Maryland Washin	gton	Hage	erstov	vn			1 Yes	2 🗆 No
death with the Maryland ms 23a or 28a-f show	Funeral Director	10e. Street and Number 124 Wayside Avenu	e		10f. Zip (		1	0g. Citizen of V USA	What Country?	
ours efter al', or ite	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Vas Decede f Yes, specif I ☐ Yes 2	ont of Hispanic Origin? (Sty Cuben, Mexicen, Puerl	specify Yes or No- to Ricen, etc.)		e - Americen Indian, ck, White, etc. White	
hould be filed within 72 hours ef id Mental Hygiene. mærked other than "natural", or mætic event, fre Medical Exerc	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give life. L	lent's Usual kind of work OO NOT use	Occupation done during most of wor retired)	rking		al home	
	Be	17. Father's Name (First, Middle, Last)		Cusc	Julai		me (First, Middle, I	Maiden Sumem		
d 2 should be file th end Mental Hy 7 is marked oth traumatic event	P	Luther E. Palmer	D: 1	404 14 11			1. Tabler			
2 9 5 8		19a. Informant's Name/Relationship (T) Ralph L. Beard, II				Street end Number or Ru 4 Falling V				9
1 ST Hell		20a. Method of Disposition 1   Burial 2 □ Cremetion 3 □ F 4 □ Donallon 5 □ Other (Specify)	Removal from State	20b. Place of Disponerations Competery, crem	sition (Neme	e of per plece)	Date	20c. Location -	City or Town, State	
permit. Page Department of Important: If any injury or		21. Signature of Euneral Service Licens		Q G	Name and	Address of Facility N. Minnich Home	305 N.	Potoma	ac Street Maryland 217	
Physician /Medicai Examiner  be proposed by the principle of the principle	edical Examiner	Immediate Ceuse (Final disease or condition resulting in death)  Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	CANCER Due LS 41 ARMIC	or as a consequence to (or as a consequence)	uence of):  CREAS  uence of):  ISENSE	ANYTHMIA  AND LIVER  3/NCE 19		lenasmo	Onset and D  I day  LES Fes. 16	- 99 F.
S 00 00		resulting In death) Last		· ·		ES HEMIPE	तान्। ३			
that the death cert ed by the ettendin deteched for use	Physician/M	Part II. Other significent conditions con	ntributing to death but no	ot resulting in the un	derlying cer	use given In Part I.		bacco uee col	ntribute to the cause of	
The law requires that the death cert ate has been signed by the ettendin page 2 should be deteched for use	Completed by					<u> </u>	24a. Was a perform	n autopsy ned?	24b. Were autopsy fir available prior to completion of ce of death?	)
The law sete hes page 2	Com						1 🗆 Y	es 2 No	1 🗆 Yes 2 🗆 1	No
Physician: The interpretation of the following the physician of the following the following the physician of the following the f	Be c	25. Was case referred to medical examiner?	fospital:			Other:	ath (Check only on			
9 Physer this	n: To	1 ☐ Yes 2 ☑ No ☐ 1 ☐ Yes 2 ☐ Yes 2 ☑ No ☐ 1 ☐ Yes 2	1 Inpatient  28a. Date of Injury (Month, Dey Ye	2 ER/Outpatien 28b. Time of		d	fome 5 ☐ Reside		111111111111111111111111111111111111111	
To the Hospital or Attending Physician: The law requires th within 24 hours efter death.  To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be completely filled.	Certification:	1- Natural 5 Pending investigation 3 Sulcide 6 Could not be determined	28e. Place of Injury building, etc. (S	At home, farm, stre	М	1 ☐ Yes 2 ☐ No	28f. Location (St City or Town	reet end Numb n, State)	er or Rurel Route Numb	ber,
e Hospital 24 hours e Funeral letely filled	Medical Co	29a. Certifier   1   Cartifying Physical (Check only one)   2   Medical Examination	sician: To the best of mer: On the basis of exa and manner stated	y knowledge, death mination and/or inv	occurred at	the time, date and place n my opinion, death occu	e, and due to the coursed at the time, d	ause(s) and ma ate and place,	anner as stated. and due to the cause(s)	
To th withir To th comp	Me	29b. Signature and title of certifier	. 1 1		29c.	License number	2	9d. Date signe	d (Month, Dey, Yeer)	-
		> M Vadu	- MD	1		D 4656		9/8	3/98.	
		30. Name and address of person who co	M. D., 334			Incomatorm	Marraland	l 2174(		



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Shirley Jean Bucklew **Physician** 650 aun 4b. City, Town, or Location of Death /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Washington County Hospital Hagerstown, Washington 8. Date of Birth (Month, Day, Year) June 18,1941 If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 57 yrs if Under 1 Year Birthplace (State or Foreign Country)
 MD **Funeral** Days 235-66-9104 1 ☐ M 2 🗙 F Yrs Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or frams 23s or 28s-f shot traumatic event, the Modical Examinating must be not that MD Washington Smithsburg Director 1 ☐ Yes 2 🔀 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21508 Jefferson Blvd. 21783 U.S.A. death Funeral 12. Was Decedent Ever In U,S. Armed Forces? 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. filed within 72 hours after 1 Never Merried 2 Married ☐ Yes 2√ No f Yes, Give 21215-0020 1 ☐ Yes 2 ☐No Specify: White Specify: þ 3 ☐ Widowed 4 € Divorced Yeer or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. convience store Elementary/Secondery (0-12) Coilege (1-4or 5+) cashier / clerk 8th grade Maryland 17. Father's Name (First, Middle, Last) mit. Pages 1 and 2 should be file partment of Health and Mental Hyportant: If item 27 is marked oth y injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph William Mills Carrie Virginia Flanagan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Bucklew 13911 Pennsylvania Ave. Hagerstown, MD 21740 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Rest Haven Cem.Sept.10,1998 2 Cremation 3 Removal from State permit. Page Department of Important: if any injury or once. Hagerstown, MD Donation 5 Other (Specify) 22. Name end Address of Facility Thompson Funeral Home, Inc. P.O.Box 310 Clear Spring, MD 21722 ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, then t failure. List only one cause on each line. Physician /Medical Immediete Cause (Final diseese or condition resulting in death) Examiner Physician/Medical Examiner entially list conditions leading to immediat Enter Underlying (Disease or injury 2 Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 23b. Did tobacco use contribute to the cause of death? 6 1 1 Yes 2 No 3 Probably 4 Unknown ·by Completed 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes an autopsy performed? has This certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 88 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Division Affier Attending 1 Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after A 4 Homicide To the Hospital within 24 hours a To the Funeral C completely Illed Tifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23e) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

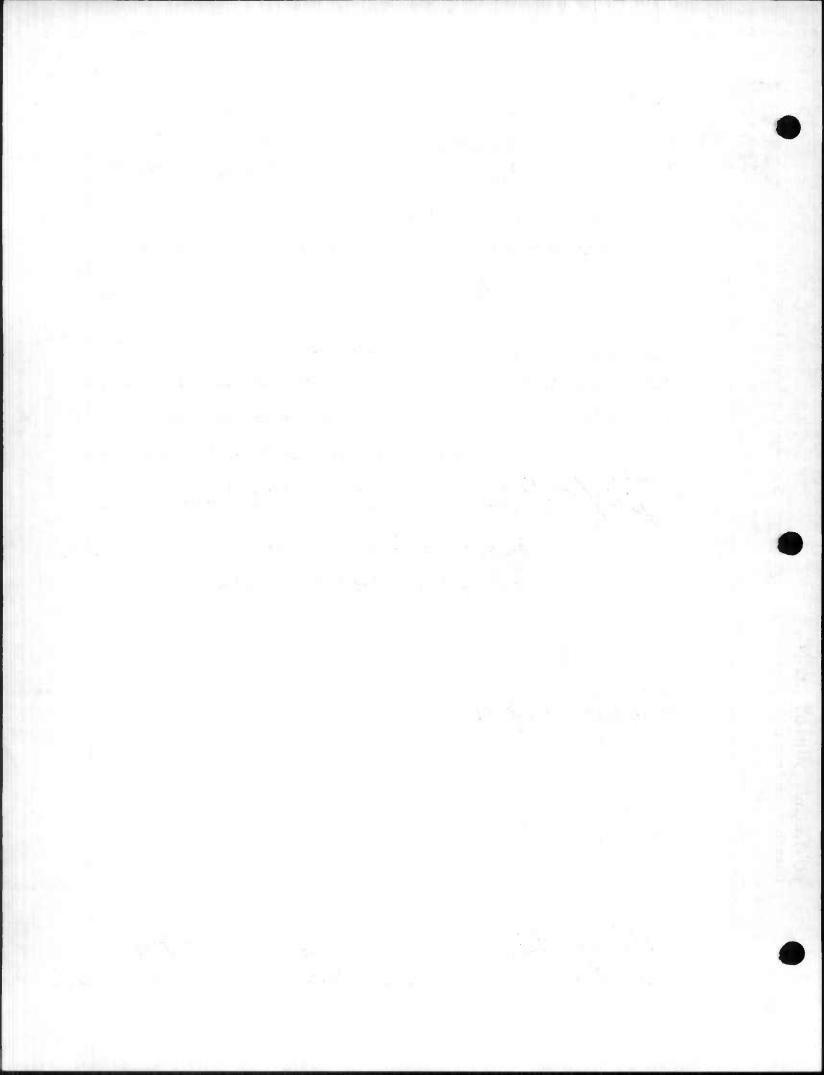
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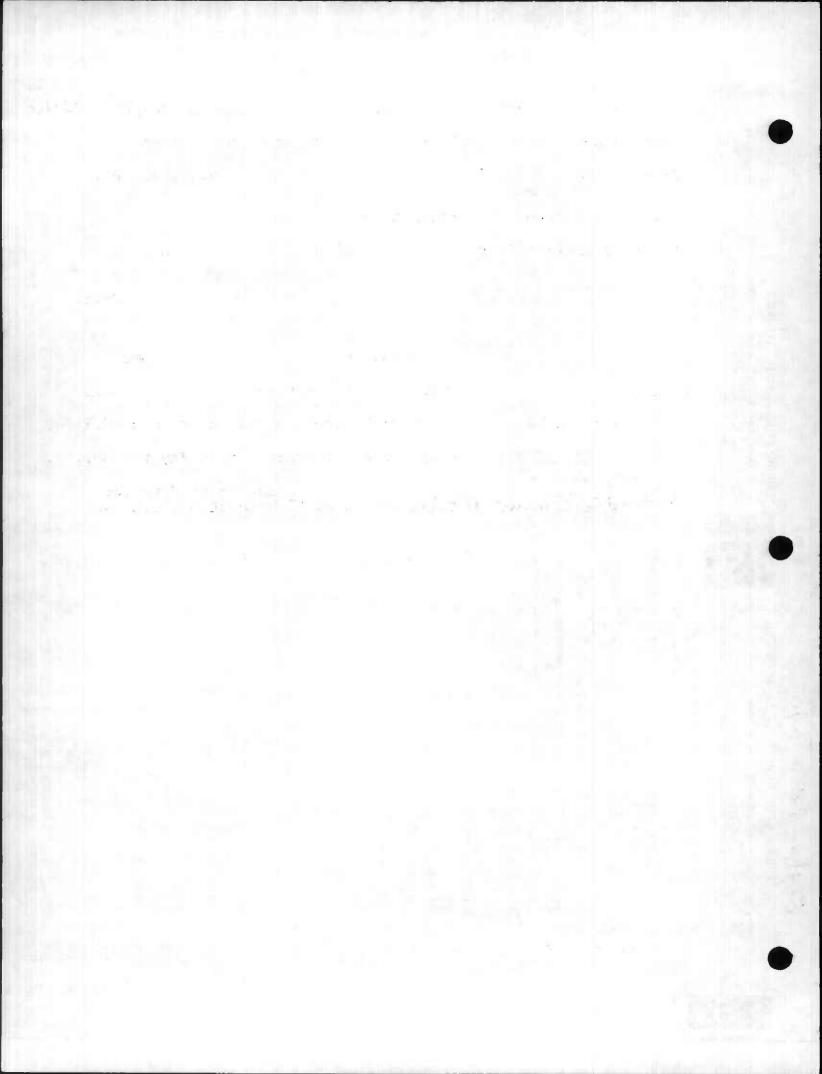


State of Maryland / Department of Health and Mental Hygiene 28732

					Ce	rtificate of	Death	7	Re	eg. No.		, , ,
Dhunia	i	1. Decedent's Neme (First, Midd					-		2. Date of Deet Month	h Dey	Year	3. Time of Death
Physic /Medi		Arthur Harold	BURGAN,	Sr.					-	6, 1998		5:45 a.m
Exami		4e. Fecility Neme (If not institution Homewood	n, give street and n	umber)				own, or Lo ederi	cation of Deeth	4c. County	of Deeth	ick
Funeral	1	5. Social Security Number	6. Sex	7. Age (In )	yrs. lest birthdey)	If Under 1 Year		24 Hrs.	8. Dete of Birth	26 - 1	9. Birtho	blece (Stete or Foreign
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ylend mor		10a. Stete 10b. County	1	10c.	City, Town or Le	ocation					1	0d. Inside City Limits
Mar	to	Maryland Was	hington		Th	urmont						1 ☐ Yes 2 ☒ No
h the	Director	10e. Street and Number	7.1			10f. Zip Code			10	0g. Citizen of V	Whet Cour	ntry?
th will		10905 Old Fred	erick Roa	ıd			21788			Į	JSA	
n 72 hours efter death with the Manyland *natural", or Hems 23a or 28a-f show edical Exacities must be portified at	by Funeral	11. Meritei Stetus  1 □ Never Merried 2 ☑ Mer  3 □ Widowed 4 □ Divorces	Armed F	2 ☑ No Sive		Wes Decedent of If Yes, specify Cut			ecify Yes or No- Rican, etc.)		k, White,	ean Indien, etc. ite
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th and Mentel Hygi 7 Is marked other traumetic event, II	To Be C	17. Fether's Neme (First, Middle, Roger Burgan	Last)						(First, Middle, M la Kira		10)	
		19e. Informent's Neme/Reletions Arthur H. Burg		- son		ng Address (Stree Maplevi						
PEE		20e. Method of Disposition			b. Plece of Dispo	osition (Neme of metory or other pla	aca)	1	Dete	20c. Location -	City or To	own, Stete
ant: If he		1 ☑ Buriel 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (S		n State		ven Ceme		9	-10-98	Hagers	town	,Maryland
Departmen Important: any Injury ance.		21. Signeture of Funerel Service	Licensee		2:	2. Neme end Addr	ess of Fecil	ity MIN	NICH FU	NERAL H	HOME	
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ding physician and ise as the buriel-transit	/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest	b c		o (or es e consec							\
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signe d be d	d by		- 1010		1 - 01		,	-	242 1112	n outcom	245 141	oro autonou findina
been si should	ete								24e. Wes er periom		ev	ere autopsy findings eileble prior to mpletion of cause
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五百	To	1 Yes 22 No 27. Menner of Deeth	28a. Dete		2 ER/Outpaties 28b. Time o	nt 3LI DOA	300		ne 5 Reside 28d. Describe ho			y)
After	tion	Naturel 5 Pendir	ng (Mo	nth, Dey Year	) Injury	We	ork? ∃Yes 2⊟		LOG. DOGONOG NO	in injury occur.	00	
winn z4 nours effer death.  To the Funeral Director: After thi completely filled in by the funeral	Certification:	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Piec	e of Injury - A	at home, ferm, str ecify)	reet, fectory, office			28f. Location (Str City or Town		er or Rura	tl Route Number,
urs el												
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		· / AA	Mes !	( ).	-	140	D1	6428		ala	19	Q
		30. Neme end address of person	who completed ceu	use of deeth (i	item 23e) (Type,	Print)				11-1	1	0
		Dr. Casper E.				Frederic	ck, Md	. 21	701	1	•	
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State of Maryland / Department of Health and Mental Hygiene 28733

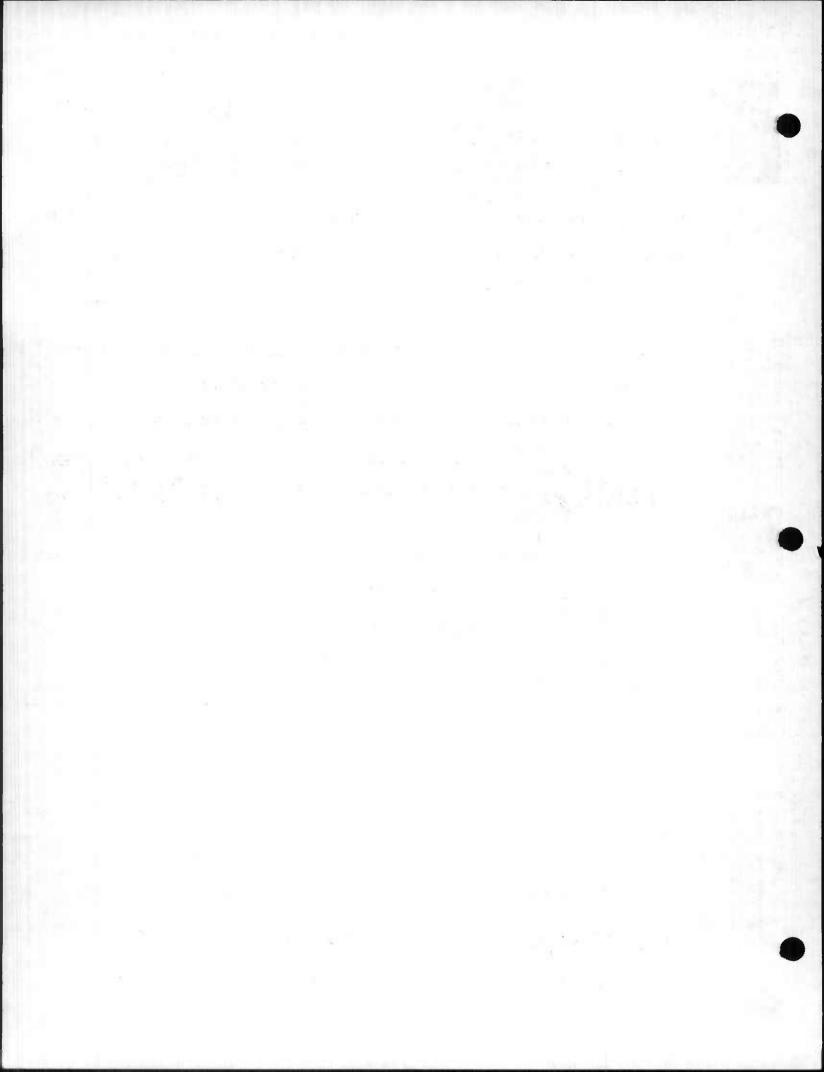
			Certific	ate of D	eath	R	leg. No.		
	1. Decedant's Nama (First, Middla, Last	)			2	Data of Dea	th Day	Year.	3. Tima of Dea
Physician /Medical	Esther	Fern	Boyer		5	eptemb	er 5 1	998	0240
Examiner	4a Facility Nama (If not institution, giva	street and number)		4b.	City, Town, or Local		4c. County	of Death	
	Washington Cou	inty Hospit	cal .	На	agerstow	n	Washi	ngto	n
Funeral	Social Sacurity Number 6. Sa					. Data of Birth (Month, Day			aca (Stata or Fo
Director	217-56-1504	™ % F 54	Yrs.	UIO Dayo	S	ep.24	,1943	Pa.	.,,
D .	Usual Rasidanca of Dacadant	40-	0. 7.			•			A 1-21-06-11
2 should be filed within 72 hours after death with the Manyland and Mental hygiena.  Is marked other than "natural", or itema 23a or 23a-f show raumatic event, the Medical Examinational Director  To Be Completed by Funeral Director	Md. Washingt		City, Town or Location					10	od. Insida City Li 1 ☐ Yas 2√3
cto	rid. Wastiringt	.011	agerstown						
23a or 28a-f show	10e. Street and Number 16907 Springlak	te Court	101	. Zip Coda 21740			10g. Citizen of V USA	What Coun	try?
r items 23.	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U,S. 13. Was D	ecedant of Hisp specity Cuban,	panic Origin? (Specif , Maxican, Puarto Ric	y Yas or No- can, atc.)		a - Amarica ck, Whita, a	
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d by		Yaar or Datas:		Λ					
it, tre Maxical Ex.	15. Decedant's Edu (Specify only highast grad	lcation la complatad)	16a. Decedant's (Giva kind o	Usual Occupati f work dona du	ion ring most of working		16b. Kind of Bu	usinass/Ind	lustry
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event, Be C	17. Fathar's Nama (First, Middla, Last)				18. Mothar's Nama (F	rirst, Middia,	Maldan Suman	na)	
To ation	Walter	F	Ravenscra		Esther			Fer	
in and Mental hyglena. 7 Is marked other ther traumatic event, treat. To Be Comp	19a. Informant's Name/Ralationship (T)				nd Number or Rural F				
Department of Health Important: If item 27 I any Injury or other transitions.	Dave Boyer/Hush				lake Ct.				
If item 27 or other to	20a. Method of Disposition  1 Burial 2 Cramation 3 DF		<ol> <li>Place of Disposition cematary, cramatory</li> </ol>	or other placa)	)	Data	20c. Location -		
iry o	4 □ Donation 5 □ Other (Specify)		ınset Vie	w Ceme	etery 9/	8/98	Fayett	e Co	., Pa.
Important: I any injury o	21. Signature of Funaral Sarvice Licens	00	22. Nam	a and Addrass					
Departr Importa any inju	01-002	his h	TC		Burner '	Trade	Sercv	ries	
10000	23a. Part1. Entar tha disaasa, or compleshock, or heart failura. List only o	lications that caused the d	aath. Do not antar tha	Dual mode of dving.	Pl. Hage	rstow aspiratory ar	n, Md. 2	1740	Approximata
husielen	shock, or haart failura. List only or	na causa on aach lina.						1	Intarval Betwee Onsat and Daal
ysiclan Medical	Immediata Causa (Final	A.	11 .		,				,
aminer	disaasa or condition rasulting in daath)		n-Hodsl		Lymph	ona		- 1	1 year
<u> </u>		Dua to	o (or as a consaquance	i of):					
in and hat-transit Examiner		b						1_	
ai-tra	Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Disaasa or Injury	Dua	o (or as a consaquance	1 01):				1	
physician and s the burial-transit	Causa (Disaasa or Injury that initiated avants	c							
physicials the burner and call	rasulting in death) Last	Due to	(or as a consequance	of):					
ding p		d							
e attending physician and kd for use as the burial-transition of the contract						4		1	
54 >	Part II. Other significant conditions con	ntributing to death but not	rasulting in tha undarly	ing causa givan	n In Part I.	23b. Did t	/		the cause of d
detac detac						101	Yes 2 No	3 Prot	oably 4 Uni
5 2 5								Dah We	us sutansu findi
page 2 should						24a. Was	an autopsy mad?	ava	ara autopsy findi ailabla prior to
has by ge 2 st								of	mplation of caus death?
Page						101	as 28 No	10	Yas 2□ No
rector, pag	25. Was casa ratarrad to medical				26. Placa of Daath (	Check only o	na)		
his ce	axaminar?	Hospital: 1 Inpatiant 2	ER/Outpatient 3	DOA Othar	4 ☐ Nursing Home	5 Rasio	tance 6 Ott	nar (Specify	y)
ar th	27. Manner of Death	28a. Data of Injury (Month, Day Year	28b. Tima of Injury	28c. Injury a	at 28	d. Dascribe t	now injury occur	rred	
y the funer	1 ☑Natural 5 ☐ Panding 2 ☐ Accident Invastigation	(WOTH, Day 16a)	M		as 2 □ No				
Certification:	3 Suicida 6 Could not be	28a. Placa of Injury - A	t homa, farm, straat, fa	ctory, office	28	f. Location (S	Street and Numi	ber or Rura	l Routa Number
er de	4 Homicida	building, atc. (Spe	ecify)			City or Tou	vn, Stata)		
= 7		sician: To the bast of my l	cnowladga daath occu	rrad at the time	data and placa, an	d dua to tha	cause(s) and m	annar as si	ated.
edical		nar: On the basis of axam and mannar stated.							
compietely	29b. Signatura and titla of certifiar	and marmar stated.		29c. Licansa	number		29d. Data signe	ed (Month.	Day, Year)
8	michael 1.	Milanak	10.0				4 -		
					11667		1 - 3	18	
	30. Nama and addrass of person who or Michael J. Mc Co	omplated causa of daalh (	tam 23a) (Type, Print)			,	,		
	Michael J. Mc Co	rmack 11	110 Medie	rel (u	nous Ro	1. 301	re 130	Deser	stown, N
State	31. Data filad (Month, Day, Year)	32 Hegistrars Si	gnatura /	1	,				



Bollam, Sanual G.

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		1. Decedent's Name (First, Middle, Last)								Reg. No.  2. Date of Death 3. Time of Death			
Physicia	n	SAMUEL GEORGE BALLAM							Month Dey		Year	2221	
/Medica Examine	-	4e. Fecility Name (If not institution, give street and number)  4b. City, Town, or							own, or Lo	JCAL O TY			
		WASHINGTON COUNTY HOSPITAL HAGERS								COWN WASHINGTON			
uneral irector		218-24-9143	Sex 1 M M 2 □ F	Age (In yrs 68	. last birthda Yrs.	Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day MAY 6,	7 Year) 1930	9. Birth Cou OH	place (Stete or Foreign ntry) IO
Examiner mant be notified at	- 1	Usual Residenca of Decadant  10a. Stete 10b. County		10c. C	ity, Town or	Location							10d. inside City Limits
	0											1 ☐ Yes 2X No	
	2 -	10e. Street and Number 10f. Zip Code								10g. Citizen of What Country?			
	<u>a</u>	21279 MT. LENA ROAD						21713			U.S.A.		
	runerai	11. Maritel Status	Armed Force	12. Was Decedent Ever In U,S. Armed Forces? 1 ⊠ Yes 2 □ No 1947-		<ol> <li>Was Decedent of Hispenic Origin? (State Yes, specify Cuban, Mexican, Puerto</li> </ol>		lgin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bla	<ol> <li>Race - American indien, Black, White, etc.</li> </ol>		
	Dy	1 ☐ Nevar Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠ Yes 2[ It Yes, Give Yeer or Date	10		1 🗆 Yes	2 🔯 No	Specify:	:		Speci	fy: T.T.	HITE
1	9	15. Decedent's E	ducation	s. 1 <i>9</i>	16a. Dec	cedent's Usu	ai Occur	pation			16b. Kind ot f		
	Completed	(Specify only highest gr	ade completed) College (1-40	or 5+)	(Gir	ve kind of wo . DO NOT L	ork done isa ratire	during mos d)	st of work	ing			,
	0	Elemantary/Secondary (0-12)	ounogo (1 11		COMM	JNICAT	IONS	SPEC	IALI	ST	FEDERAL	GOV	ERNMENT
6	e a	17. Father's Neme (First, Middle, Last								e (First, Middle, Maidan Sumame)			
	2	OLIVER J. BALLAM								E. SOUDERS			
		19a. intormant's Name/Relationship GLENDORA R. BALL		7						Route Numbe			
		20a. Method of Disposition	MI SECUSI	20b.	Place ot Dis	position (Na	me of		υ, Β	OONSBORO	20c. Location		21713 own, State
		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Removal from Sta	te		rematory or			0.7	10/00			
Important: If fem 27 is it any injury or other traunonce.	-	21. Signety e of Funeral Service Lice		IVI		A CEME 22. Name e			9/ ty				MARYLAND
		Paul M. Dean BAST FINERAL HOME 7606 Old National Pike											
	1	23a. Part , Enter the disease, or com	plications that caus	ed the dee	th. Do not e	enter the mo	de of dyin	ng, such es	cardiac	or respiratory an	est.	cytan	Approximata
n il er		23a. Part . Enter the disease of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heert tailure. List only one cause on each line.  Approximata Interval Between Onset and Deeth  Immediate Cause (Finel disease or condition resulting in death)  a. Coronary 15 Clesic											
	5					equenca ot)		liseare					
Evaminar		Sequentially list conditions	b	Dua to (	or es e cons	equence of		Hears	ر			1	
u	Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Disease or injury c. Hypn As leaters).												
dicai	2	that initiated events resulting in death) Last Due to (or es e consequence of):										1	
Mo	1		d									i	
o io	5									T		1	
Dhyeirian Mad		art II. Other eignificant conditions contributing to death but not resulting in the underlying causa givan in Part i.							l.	23b. Did tobacco use contributa to the causa of death?  1 Yes 2 No 3 Probably 4 Unknown			
Completed by										24a. Was a		64	ere autopsy tindings aileble prior to
alun	1										completion of caus of death?		
										1□ Y	1 Yes 2 No 1 Yes 2 No		
a Unector: After this certificate he led in by the funeral director, page Certification: To Be Com	2	25. Was casa referred to medical examiner?	Hospital:				Oth	300		(Check only or			
		1 Yas 2 No  7. Manner of Death 1 Phatural 5 Pending 2 Accident investigatio	28a. Date of injury 28b. Time of injury 4 Norsing Home 5 Residence 6 Other (Specify)  28c. Injury at Work?  28d. Describe how injury occurred Work?										
Hifica		2 Accident investigation 3 Suicide 6 Could not be datarmined 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Spacify)								28f. Location (S	treet and Num	ber or Run	al Route Number,
completely filled in by the	5												
	3	29a. Cartifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and piace, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data end piaca, and due to the cause (s) and manner as stated.									stated. o the causa(s)		
2		29b. Signature and title of cartitier mo					29c. License number D 26579			2	29d. Dete signed (Month, Dey, Year)		
	3	0. Nama and address of person who	completed cause of		1	e, Print)	11	, ,		Manylan	1 2	2//2	
		12. L. Kugler MI	747	Nov	H.	Line	H	apestis	Alb	M Grylan	d LI	142	



## **Physician** /Medical **Examiner Funeral** Director the Maryland "natural", or items 23s or 28s-f show Directo B filed within 72 hours efter death Hygiene. Funer þ Completed other than "natur markad

signed by the e been si director, this After this 4rthor ŏ To the Hosp within 24 hor To the Fune completely fi

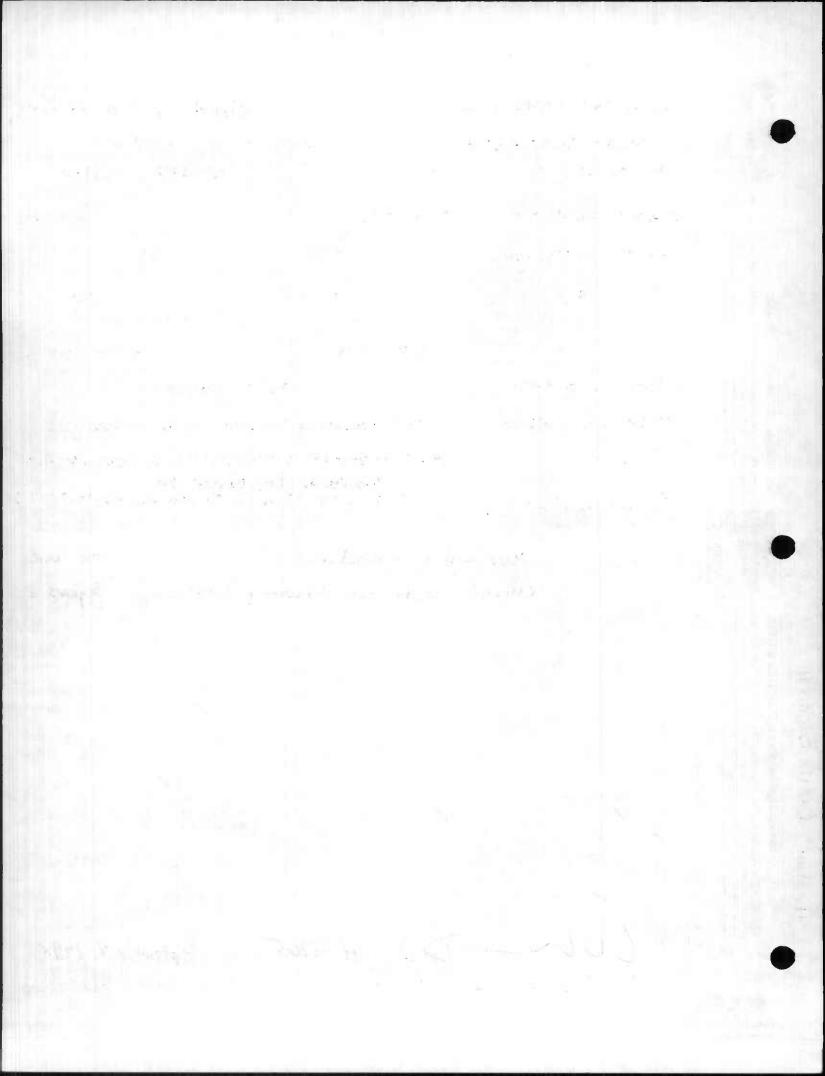
Bachtel

Pecil

2. Data of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth Day Month Arthur Cecil Bachtell, Sr. 12:45pm 4b. City, Town, or Location of Death 3 4a Fecility Name (If not institution, give straat end number) 4c. County of Death Washington County Hospital Washington Hagerstown 5. Social Security Number If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) OCt. 28, 1942 6. Sex 7. Aga (In yrs. last birthday) Birthpiaca (Stata or Foreign Country) 18 M 2□ F Months Days Hours 213-40-4745 55 Maryland Usual Rasidanca of Dacedant 10c. City, Town or Location 10a. Stata 10b. County 10d. Inside City Limits Maryland Washington Clear Spring 1 ☐ Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 15033 Hicksville Road 21722 USA 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ②No If Yas, Giva Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, atc. 1 ☐ Navar Married 2 ☐ Married 1 Yas 2 No Specify: Specify: White 3 Widowad 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade complated) (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elementery/Secondary (0-12) College (1-4or 5+) Cabinet Maker 0 Kitchen Cabinet Mfg. 12 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fether's Nama (First, Middle, Last) Pages 1 and 2 should be 1 Arthur K. Bachtell Helen Stottlemyer 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) William A. Bachtell/Son them 27 I 19710 Longmeadow Road, Hagerstown, Maryland 21742 20a. Mathod of Disposition 20b. Piace of Disposition (Nama of cematary, cramatory or other place) Date 20c. Location - City or Town, Stata important if the any injury or oth 9000 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Cedar Lawn Memorial ParkSept. 8,1998 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility
Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N., Hagerstown, Maryland 21742 1331 Eastern Blvd. N., Hagers
23. Pert1. Enter the disagree, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximata intarvai Batween Onsat and Death **Physician** /Medical Immediata Causa (Final · MyoCardial diseasa or condition rasulting in daath) Examiner Examiner Puluman Disease Chronic 0BS+ructure physician end the buriel-transit requires that the death certificete be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting In daath) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequance of): 98 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown by 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed s certificate hes director, pege 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa referred to medical examinar? Be 26. Piece of Death (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Menner of Deeth 28a. Date of Injury (Month, Day Yaar) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Panding 1 Tas 2 No Investigation 2 Accidant Director: / 6 Could not be determined 3 Suicida 28e. Pleca of tnjury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) in 24 hour.
The Funeral Dir.
Trilled in by 4 Homicide 29a. Certifier 🕼 Certifying Physician: To tha best of my knowledga, daath occurred at the tima, date and plece, end due to the ceuse(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and menner steled. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c, License number 30. Nama and addrass of person who completed cause of deeth (Item 23a) (Type, Print) st. Hagerstown Maryking Winke North 31. Data filed (Month, Day, Year) 32. Ragistrar's Signature State SEP 04 1998 Registrar

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Charlotte Love Boward Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** 0516 A CHARLOTTE 130WARES Love SEPT /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner ital Hagerstown Washington

7. Age (In yrs. lest birthday)
75 Yrs. Months Days Hours Min. Nov. 23, 1922 West Wirginia Washington County Hospital 6. Sex 1 □ M 2√ F 9. Birthplace (Stete or Foreign **Funeral** 217-12-2174 Director Usual Residence of Dacedent death with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturel", or items 23a or 28a-f show Washington 1 Yes 2 No Director Maryland Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1090 Marshall Street 21740 USA Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. filed within 72 hours aftar 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Giva Yaar or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify. Specify: White 31☑ Widowed 4 □ Divorced should be and Mental Hygiena.
so marked other than "nature!" 15. Decedent's Education (Specify only highest grada completed) 16e. Decedent's Usuai Occupetion (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) Clerk The Bon Ton 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meidan Sumeme) Pages 1 and 2 should be 1 ant of Haalth and Mental I nt: If item 27 Is marked of Martin Myrtle Symons 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 69 Greencastle, Pennsylvania 17225

Dete | 20c. Location - City or Town, Stete or other t Donald B. Boward 14934 Sherwood Drive Son 20e. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Remove from State Department of Important: If any Injury or once. Cedar Lawn Memorial Park 9/8/98 4 ☐ Donetion 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland 21740 enter the moda of dying, such as cardiac or respiratory errest, Approximate 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not e shock, or haart failure. List only one ceuse on each line. **Physician** Immediete Ceuse (Final diseese or condition rasulting in deeth) /Medical 2 2 Acote myocardal Examiner Examiner Artierrosc (enotic or Attending Physician: The law requires that the death cartificate be executed after death.

Director: After this cartificate has been signed by the attending physician and tha burial-transit Sequentially list conditions, if eny, laeding to immediata cause. Entar Underlying Cause (Diseesa or Injury that initieted evants resulting in deeth) Lest Due to (or es e consequence of) Box 68760. Physician/Medical Due to (or es e consequence of) 8 signed by the attanding to be datached for usa P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were eutopsy findings evelleble prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? 1 Yes 2€ No 1 ☐ Yes 2 ☐ No funaral director. 25. Was case referred to medical exeminar? Be 26. Pleca of Daath (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1- Inpatient 2 □ ER/Outpetient 3 □ DOA 27. Menper of Death 28a. Data of Injury (Month, Dey Year) 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No invastigation 2 Accidant In by tha 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital 24 hours a Funeral C 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, deta end pleca, end due to tha ceuse(s) end menner es stetad. 29e. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) and menner steted. To the I within 2 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) ween. en wis 9-3-95 288500

State Registrar 30. Nama and address of person who completed cause of daeth (Itam 23a) (Type, Print)

Dr. Hornbaker

1 0 1998

31. Dete filed (Month, Dey, Year)

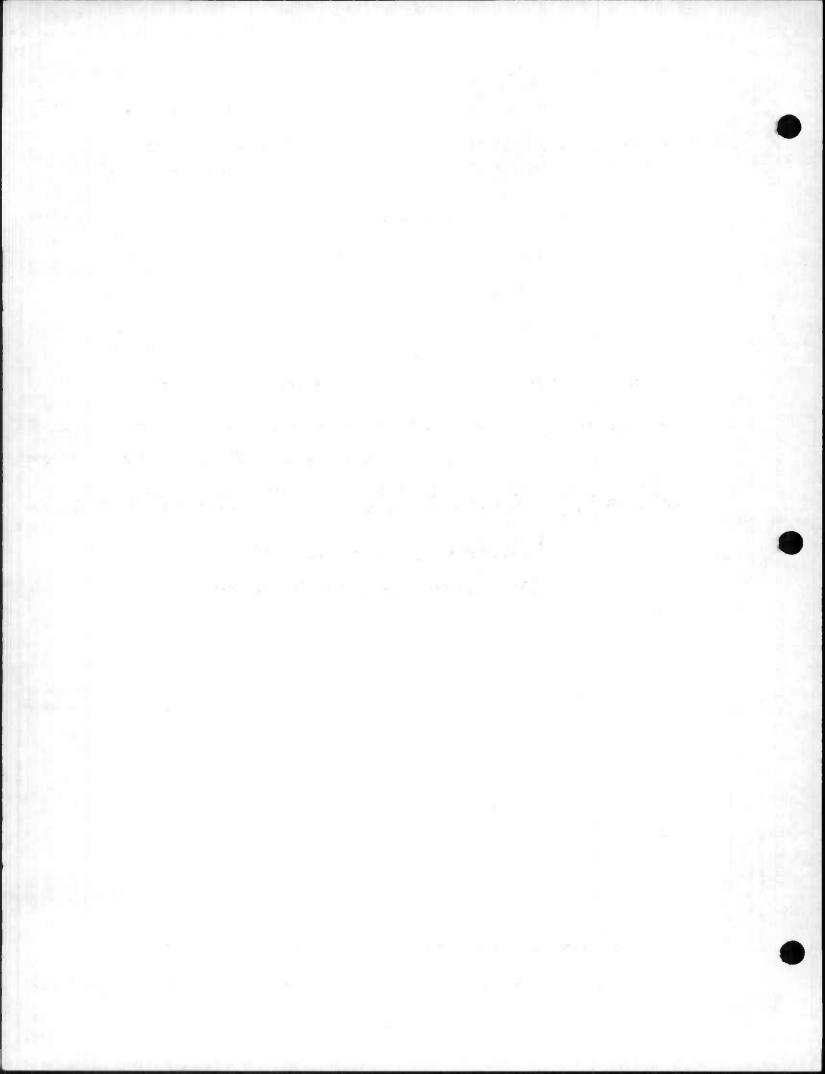
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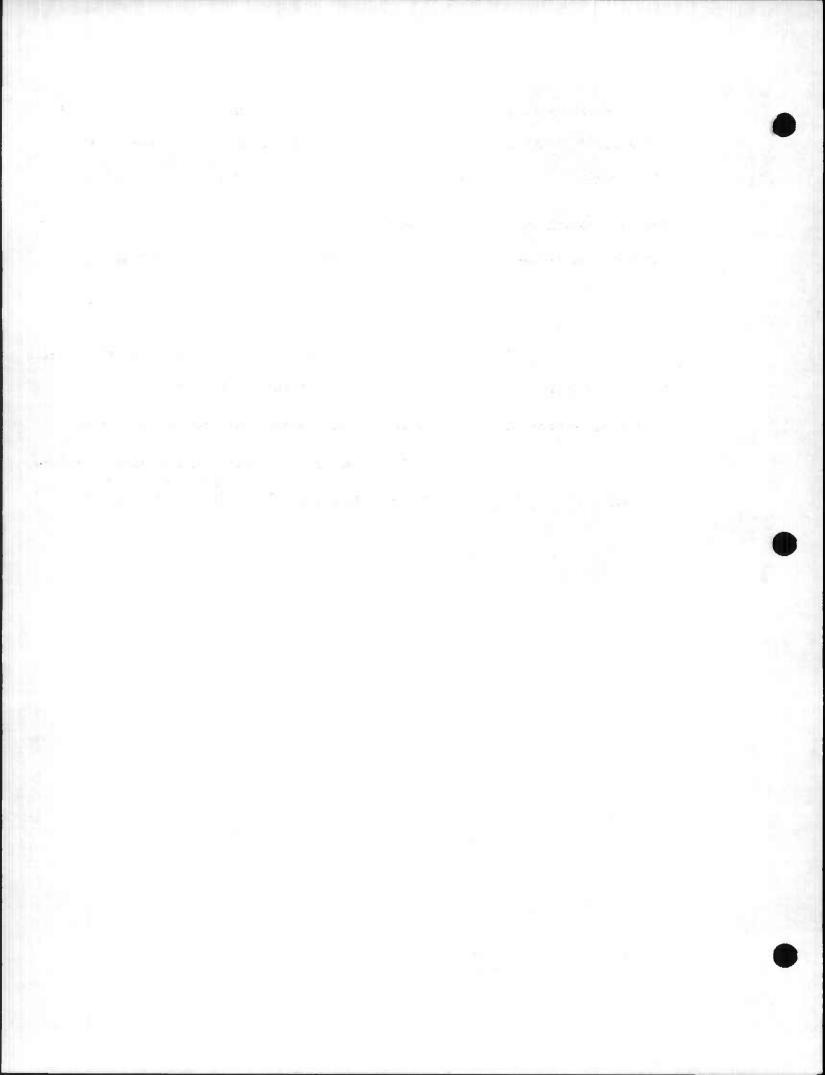
Campus

Hagerstown Maryland



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Physician /Medical						ertificate of		1	eg. No.		
		Decedent's Name (First, Middle, L	ast)					2. Date of Dear Month	Day	Year	3. Time of Death
	١,	Catherine Iren					# 6% T	Sept.	1 199		3.40 PM
Examiner	1	la. Facility Name (If not institution, g		ber)			4b. City, Town, or Lo		4c. County		
	4	17616 Burnside			1	/) If Under 1 Year	Hagersto			ingto	
Funeral	1		Sex 1□M 2∏F	1 M 2 M F Months				8. Date of Birth (Month, Day	Year)		ace (State or Forei
Director	1	215-20-7986 Usual Residence of Decedent	- A	69	110.			Dec. 21	1928	Mary	land
ž	_  -	IOa. State 10b. County		10c. C	ity, Town or I	_ocation				10	d. Inside City Limi
4 2 b	5 ,				77						1 ☐ Yes 2 🔯 N
or 28a-f ahow be notified at Director	3	Maryland Washin	gton		над	erstown 10f. Zip Code			0g. Citizen of V	Mast Count	
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Fleath and Mental thygiene.  Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinst must be notified at To Be Completed by Funeral Director	3	17616 Burnside Av 11. Marital Status		ont Ever in I	16 110	217		ach. Van an Ma	U.S	· A · e - America	an Indian
F F S	5		12. Was Deced Armed Ford 1 Tes 2	es?	,3.	. Was Decedent of F if Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)		k, White,	
by F		1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Dat			1□ Yes 2∏ No	Specify:		Specify	. Wh	ite
E E	-						- Ala-		40h Kindat D		
ygiene. er than 'natura ft, the Medical ft. Completed		15. Decedent's (Specify only highest g			(Giv	edent's Usual Occup e kind of work done DO NOT use retire	during most of work	ing	16b. Kind of B	Jsiness/ind	ustry
than the		Elementary/Secondery (0-12)	Coltege (1-4	for 5+)		rk - Reta			Potail (	Cloth	ing Sales
E E		7. Father's Name (First, Middle, Las			OTE	IK - Keta	18. Mother's Name				ing sales
and Mental Hygiene. s marked other than summit event, the M	1	Samuel Lee Guess	,					rine Warden			
merke umatic					40h Mail	Non Address (Otropo		TINE WATGEN  Aural Route Number, City or Town, State, Zip Code,			
h an traur		19e. Intorment's Name/Relationship									
Health em 27 I		Edward Blair – Hi Oa. Method of Disposition	isband	20h		6 Burnsid					
or of H	1	1 XBurial 2 ☐ Cremation 3	☐Removai from St	20b. Ptace of Disposition (Name of commetery, cremetory or other placa)  Rose Hill Cemetery			ca)	Date	20c. Location -	City or To	MI, State
Lant	L	4 Donation 5 Other (Spec	ify)	ry 9	/4/98 I	lagerst	own, l	Maryland			
Department of Health & Important: If Item 27 is any injury or other tra		21. Signatura of Funeral Service Lio	nsee n	-	1	22. Name and Addre	ss of Facility M	innich E	uneral	Home	
0 = 9 9		22. Name and Address of Facility Minnich Funeral Hom 415 E. Wilson Blvd. Hagerstown, Md.									
nysician Medical kaminer		Immediate Cause (Final disease or condition resulting in death)	a	L (	or as a conse	Cancer equence of):					Interval Between Onset and Death
physician end s the burlat-transit		Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b	Due to (	or as a conse	equence ot):					
physicials the burner of the b		Cause (Disease or Injury that initiated events resulting In deeth) Last									
d by the attending stached for usa a Physician/M											
the the d	F	Part II. Other significant conditions	contributing to deal	th but not res	sulting In the	underlying cause giv	en in Part i.	23b. Dtd to	bacco use co	ntribute to	the cause of deat
igned by the a be datached to be datached to by Physic							1⊡4	es 2 No	3 Prob	ably 4 ☐ Unkno	
2 should								24a. Was a perform	n autopsy med?	con	re autopsy tindings Itable prior to apletion of cause leath?
page page								1 🗆 Ye	es 2 No	1 🗆	Yes 2□ No
certificata rector, pa		5. Was case reterred to medical					26. Place of Deatl	h (Check only on	ne)		
0 E 0		examiner? 1 Yes 2 No	Hospital:	patient 2	ER/Outpatie	ent 3 DOA Oth	or.	me 5 Reside		er /Specify	) .
Aftar thi funaral funaral		7. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of (Month,		28b. Time tnjury	ot 28c. Injur		28d. Describe ho			
within 24 hours after death. To the Funeral Director: After to completely filled in by the funer Medical Certification:		3 Suicide 6 Could not determine	200. Place of	28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify)  28t. Location City or 1						er or Rural	Route Number,
in 24 hour he Funera pletaly filli edical		29a. Certifier 1 Certifying P (Check only one) 1 Medical Exs	hysician: To the be miner: On the basi and manne	is of examina	owledge, dea atlon and/or li	th occurred at the tir nvestigation, in my o	me, date and place, pinion, death occurr	and due to the cred at the time, d	ause(s) end me ate and place,	nner es sta and due to	nted. the cause(s)
To the		9b. Signature and title of certifier				29c. Licens	e number	2	9d. Date signe	d (Month, E	Day, Year)
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	-	O Name and address of account	nomol-ted	of double ess	m 00-1 /-	Dules!					
	3	Michael J. McC		of death (Ite	m 23a) (Type	Mich land	1 1	c · 1	130 1	4	6. 1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Daath 3. Time of Death CATHERINE BOWERS 28, 1998 August 2:45 AM 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Ravenwood Lutheran Village Hagerstown Washington 8. Data of Birth (Month, Day, Yaa, Nov. 2, 1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) Days Months 1□ M 20 F Hours 90 217-32-5254 Yrs Maryland Usual Rasidanca of Dacedant 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 X Yas 2 □ No Washington Hagerstown 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 12 Fourth Street 21740 USA 12. Was Decadant Evar in U.S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amarican Indian, Black. Whita, atc. 1 Navar Marriad 2 Married 1 ☐ Yas 2X No If Yas, Giva 1 ☐ Yas 2 ☒ No white Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Dacedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacadent's Education (Spacify only highast grade complated) 16b. Kind of Businass/Industry Elamantary/Sacondary (0-12) Collaga (1-4or 5+) homemaker 0 her own home 17. Fathar's Name (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Surnama) Hugh O. Fisher Cora Mae Gross 19a. Informant's Name/Ralationship (Typa, Print) 19b. Malling Addrass (Straat and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda) Joyce M. Isanogle - daughter 12 Fourth St., Hagerstown, Maryland 21740 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Othar (Spacify) Mt. View Cemetery 8-31-98 | Sharpsburg, Maryland 22. Nama and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funaral Sarvica Licansae 415 E. Wilson Blvd., Hagerstown, Md. COCTI 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batw Onset and Death Immediata Causa (Final Arteriosclerotic Cardio Vascular Disease many years Dua to (or as a consaquence of): Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical 28. Placa of Death (Check only ona) Hospital: Othar: 4XX Vursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred 28c. fnjury at Work? 5 Panding 1 Yas 2 No Invastigation 6 Could not be datarminad 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signatura and tha of certifiar 29c. Licensa number 29d. Data signed (Month, Day, Year)

Box 68760. Vital Hospital or Attending Physician: of Division To the Hospital c within 24 hours of To the Funeral D completely filled

BOWERS

Catherine

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requires that the death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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items 23a

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permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "na any Injury or other treumatic event, the Medisons.

**Physician** /Medical

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11 Marital Status

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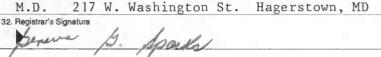
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Edward W. Ditto, III,

31. Date filad (Month, Day, Yaar)

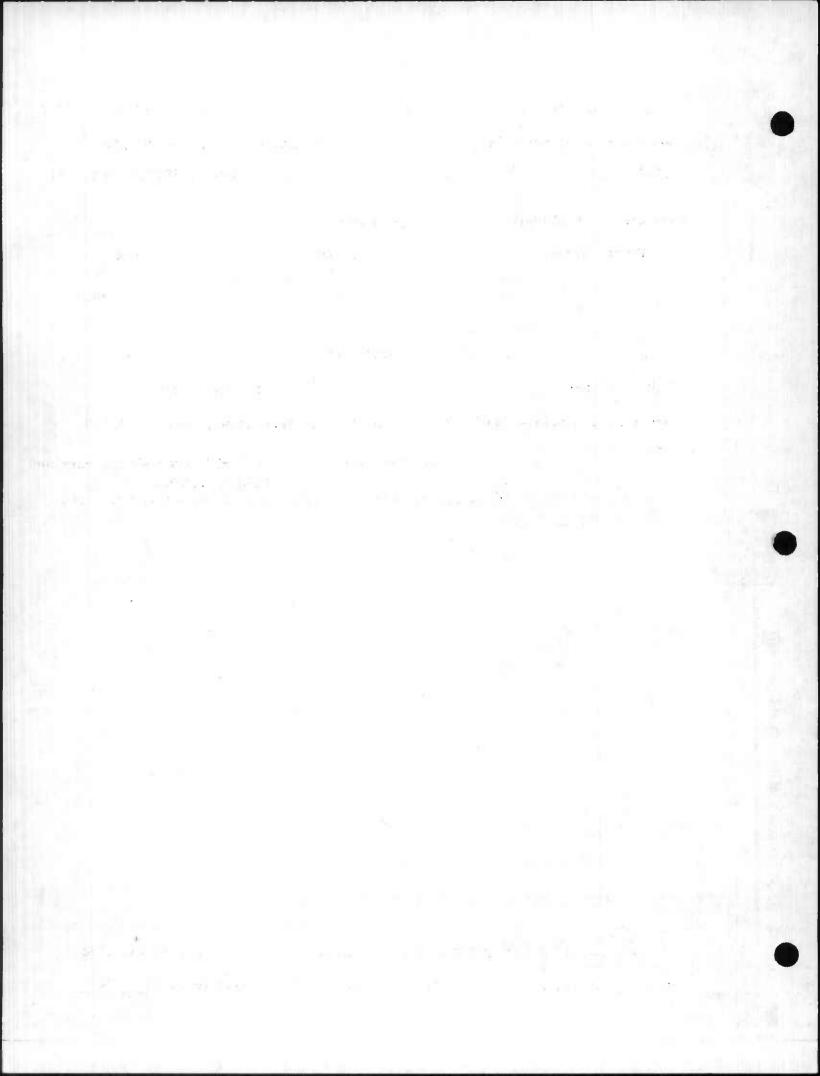
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M.D.



DO1062

August 28, 1998



Certificate of Death

Phys /Me Exa

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1. Decedent's Nam	e (First, Middle, Las	1)	ri e u	Petr .			2. Dete of Month	Deeth Dey	Yeer	3. Time of Death
4a Facility Name (	If not institution, give	iam Lee street and number) AL MEDICA	,				a, or Location of DE SALISBURY	eth 4c. County	y of Deeth	1031
5. Sociel Security N	11	9x XM 2□F	e (In yrs. last bir	thday) If Und Month	der 1 Year s Deys	Hours	Hrs. 8. Dete of (Month, 13 08-1			ece (State or Foreig try)
Usuel Residence of 10a. Stete	Decedent 10b. County		10c. City, Tow	n or Location					10	Od. Inside City Limit
	7									1 Yes 2 N
MD 10e. Street end Nu	Somers	et	Crisf		Zip Code			10g. Citizen of	What Count	X In/2
	ners Cov	0			1817					.,.
11. Merital Stetus	HEIS COV	12. Was Decedent 8	Ever in U.S.			dispante Origin	n? (Specify Yes or	U .	Ce - America	an Indien.
	ied 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N		If Yes, sp	pecify Cub	en, Mexican, I	n? (Specify Yes or Puerto Ricen, etc.)	Ble	ck, White, e	itc.
3 Widowed		If Yes, Give Yeer or Detes:		1 ☐ Yes	3√□ No	Specity:		Specif	b:Blac	ck
	15. Decedent's Ed		18e.	Decedent's Us	suel Occup	petion		16b. Kind of B	Jusiness/Ind	ustry
(Spec	cify only highest gree	de completed) College (1-4or 5		(Give kind of v life. DO NOT	vork done use retire	during most o d)	f working			
N/A	ondary (0-12)	College (1-40f 5	+)	N/A				N/A		
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William	n Lee Bo	wyer Jr.				Apri	L. Mc	Dowell		
	eme/Reletionship (7		196	. Meiling Addre	ss (Street		or Rural Route Nui		, Stete, Zip	Code)
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	☐ Cremation 3 ☐ 5 ☐ Other (Specify			ry, cremetory o		ca)				
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								es en eutopsy	24b. We	ere eutopsy findings elleble prior to
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DHMH 16 Rev 6/95

Registrar

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	1. Decedent's Ner	me (First Middle	Last)		Cert	ificate of	Death	2. Dete of Dee	leg. No.		3. Time of Deeth
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ral tor	5. Social Security 578-58	Number 76	3. Sax 1 → M 2 □ F	Age (In yrs.	lest birthday) Yrs.	If Undar 1 Year Months Deys			Year)	9. Birthpl Count	lece (State or Foraign try) aryland
	Usuel Residenca	of Decedent 10b. County		10. 04	Town and and	41					
irector	MD	Calve	rt		y, Town or Loca	ke Beacl	2			10	0d. Inside City Limits  1 Yes 2 □ No
rect	10e. Street end N		1.0		ilesapea	10f. Zip Coda	1		Og. Citizen of W	het Count	
rai Di	7340 G	Street		2073					U.S		
Completed by Funeral Director		riad 2X Marrie	Armed Forca  1 Yes 2  If Yes, Give	. Was Decedent Ever in U.S. Armed Forcas?  1 ☐ Yes, 2 ☐ No If Yes, Give Year or Dates:			dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yas or No- o Rican, etc.)		- America , White, e	
eted	-		Education greda completed)		16e. Decede (Give kl	nt's Usual Occup nd of work done	petion duning most of word)	king	16b. Kind of Bus	iness/Ind	lustry
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To	Malco	olm Fra	ncis Burg	ess			Dorot	hy	St	wecke	er
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	20e. Method of Dis	Cremetion 3	☐Ramovel from Stell		leca of Disposit emetery, creme	tory or othar ple	ce)	Date	20c. Location - 0 6633		m, Stete Alex. Ferr
	4 Donetion	5 Other (Spe	cify)		ee Crem	-		26, 199	0		MD 20735
900	21. Signature of	uneral Service Li	oensee	7	22.1	Neme end Addra	iss of Facility				
	11	2	_/		Le	e Funera	al Home,	Calvert,	P.A. O		
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	27. Manner of Dea	th 5 Pending	28a. Date of In (Month, D		28b. Time of Injury	28c. Injui		28d. Describe ho			
atic	2 Accident	investigat	ion	, , , ,	injury		Yes 2□No				
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	30. Neme and add	ress of person wh	p completed ceuse of	deeth (Mem	23a) (Type, Pr	int) A.	1	> ^ ( '7 '			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND: #5 PER F.H. G764 10-14-98 WR. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev Month **Physician** RICHARD THOMAS BUTLER, JR. September 4,1998 2:15 pm /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 4426 Gallant Green Road Waldorf
If Under 24 Hrs.
Hours Min. Charles 5. Sociel Security Number 220-07-83515 183 If Under 1 Yeer 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** 10 M 20 F Deys 88 Yrs. Director FEB. 3, 1910 MARYLAND Usual Residence of Decedent the Maryland 10a State permit. Peges 1 end 2 should be filed within 72 hours after death with the Manylan Department of Health end Mental Hygiene.
Important: If itam 27 is merked other than "natural", or itams 23s or 28s-f show any Injury or other traumatic evant, the Medical Examples must be notified at once. 10h County 10c. City. Town or Location 10d. Inside City Limits MD CHARLES WALDORF 1 Yes XXNo Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 4426 GALLANT GREEN ROAD 20601 Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Dates: WW I 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien Bleck, White, etc. 1 Never Married 2 Married 1 Yes XX No 21215-0020 Specify: þ Specify: WHITE 3 Widowed 4 Divorced WW II Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) SELF EMPLOYED PAINTING CONTRACTOR Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be RICHARD THOMAS BUTLER, SR. EMMA REESE THOMAS 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ROSINA KELLER BUTLER 4426 GALLANT GREEN ROAD WALDORF, MARYLAND 20601 20a. Method of Disposition

1 Burial 2 Disposition 3 Removel from Stete
4 Donetlon 9 Other (Specify) 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, State HUNTT FUNERAL HOME CREMATORY 9/6/98 WALDORF, MD. 21. Signeture of Funerel Samuel Line 22. Name end Address of Fecility HUNTT FUNERAL HOME, INC. M01095 3035 OLD WASHINGTON ROAD WALDORF, MD 20604 23a. Pert. Enter the diseese, or complication the shock, or heert failure. List only one cause eth. Do not enter the mode of dying, such es cardiac or respiretory errest, Approximete Onset end Deeth **Physician** Cancer of /Medical Immediete Ceuse (Final diseese or condition resulting in deeth) Examiner Physician/Medical Examiner Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest The law requires that the death certificate be execu obstructive hwnic Due to (or es e consequence of) Richard Thomas Butler Division of Vital Records, P.O. Box 68 Pert II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? is certificate has been signed by director, page 2 should be detac 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? this certificate has 1 ☐ Yes 2 No 1 Yes 2 No 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No in by the funeral Certification: 27. Megner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describa how injury occurred 28c. Injury et Work? After 5 Pending investigation Neturei 1 Yes 2 No 2 Accident **Director:** 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Medical 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner stated. 29e. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) Huasi Icens 9/4/98 D - 4564230. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cenna Medical Center Mahadevappa K,Hunasikatti,MD 7C Post Office Road,Waldorf,MD 20602

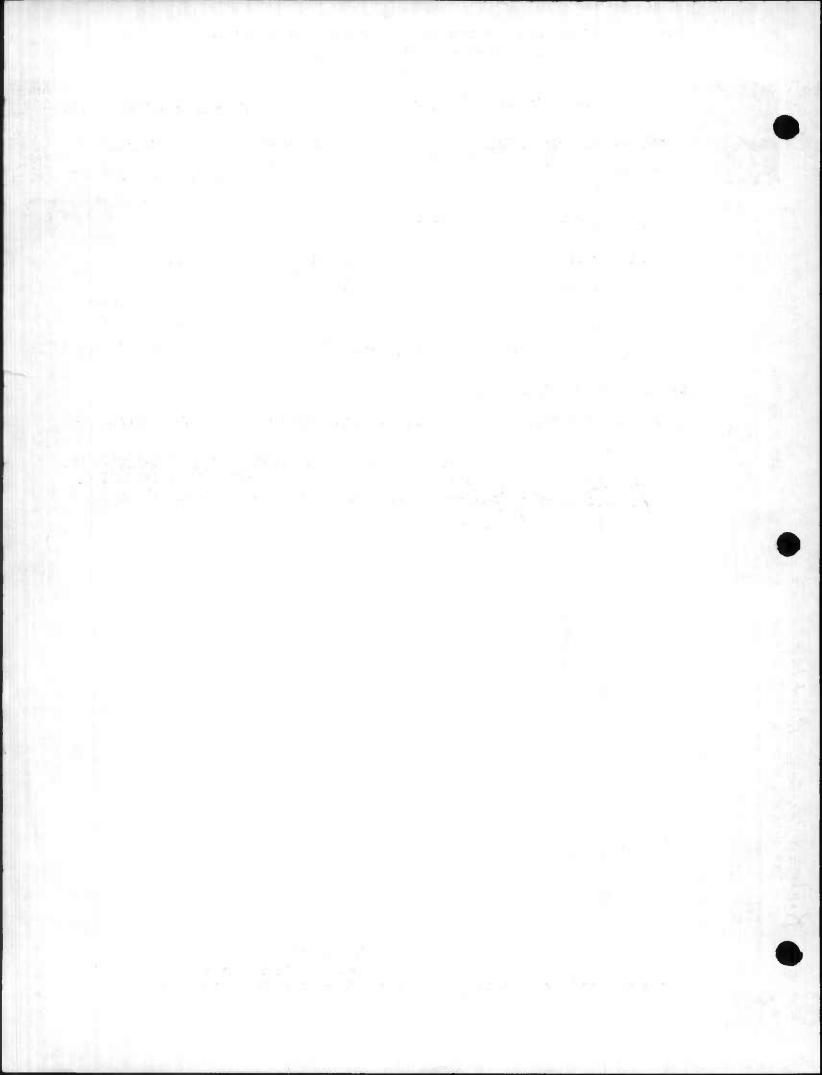
**DHMH 16 Rev 6/95** 

State Registrar 31. Dete filed (Month, Dey, Yeer)

SEP 09

32. Registrar's Signeture

1998



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) MARTIN LUKE BLADEN, JR. 2. Data of Death 3. Time of Death Day 03: 40AM Month BLADEN MARTIN SEPTEMBER 02, 1998 4c. County of Death 4b. City. Town, or Location of Deeth 4a Fecility Nama (If not institution, give straet and number) 4307 BRANDYWINE PARK KP PRINCE GEORGES FLORAL If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 5. Social Sacurity Number XXM 2DF 577-26-3804 72 16, 1926 Washington DC Usuel Residance of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2X No Maryland Prince George's Brandywine 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Coda 4307 Floral Park Road 20613 USA 12. Was Decedant Evar in U,S. Armed Forcas? 14. Rece - Amarican Indian, Black, Whita, atc. 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ⊠ Yas 2 □ No If Yas, Give Yaer or Dates: 1944-46 1 Never Married 2 Married White 1 ☐ Yas 2 X No Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Sports Self Employed 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Martin Luther Bladen Margaret Esther McNamara 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Patricia F. Bladen 4307 Floral Park Road, Brandywine, MD 20613 20b. Placa of Disposition (Nama of cematary, crametory or other place) 20c. Location - City or Town, Stata 20e. Mathod of Disposition Data 1 D Burial 2 Cremation 3 Removal from Stete Manyland Veterans' Cem. 9-8-98 Cheltenham, MD 4 Donation 5 Other (Seecify) 22. Nama and Addrass of Facility Huntt Funeral Home, Inc. peral Service License 21. Signature of I A. David Goff M01098 P. O. Box 156, Waldorf, MD 20604-0156 Approximata Interval Between Onsat end Deeth 23a. Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediata Cause (Final . ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE disaesa or condition rasulting in daath) Dua to (or as a consequence of) Sequentially list conditions, if any, laading to immadiate causa. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Lest Dua to (or as a consequence of): Due to (or es e consequenca of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS 24b. Ware autopsy findings available prior to 24a. Was an eutopsy performad? completion of cause of deeth? 1□ Yes 2 No 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only one) Othar: 4 Nursing Homa 5 Residenca 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked offin any injury or other traumatic event once.

Director

Funerai

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Baltimore, Maryland 21215-0020

physician and the burial-transit 88 attanding for ed by the a signed by t peen this cartificate has

The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

or Attending Physician:

r: After this cartifica e funeral director, p after death.

Director: After director of the fundamental of the funda

Physician/Medical þ Completed Be L<sub>o</sub> Certification:

edicai

29a. Certifier

(Check only one)

Examiner

State Registra

25. Wes casa rafarred to medical axaminar? 1 Yas 2□ No 27. Manpar of Death 1 Naturel 2 Accidant 3 ☐ Suicide 4 Homicide

28a. Deta of Injury (Month, Day Year) 5 Panding invastigation

6 Could not be 28e. Place of Injury - At home, ferm, straet, factory, office building, etc. (Specify)

28h. Tima of

28c. Injury et Work? 1 Yas 2 No

29c. License number

28d. Dascribe how injury occurred

DRIVE, CHEVERLY

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie MME

SEPTEMBER 2, 1998

29d. Data signed (Month, Day, Year)

30. Name and addrass of person who dempleted cause of death (Itam 23a) (Type, Print) MP 3001 MARIO GOLLE JR

1998

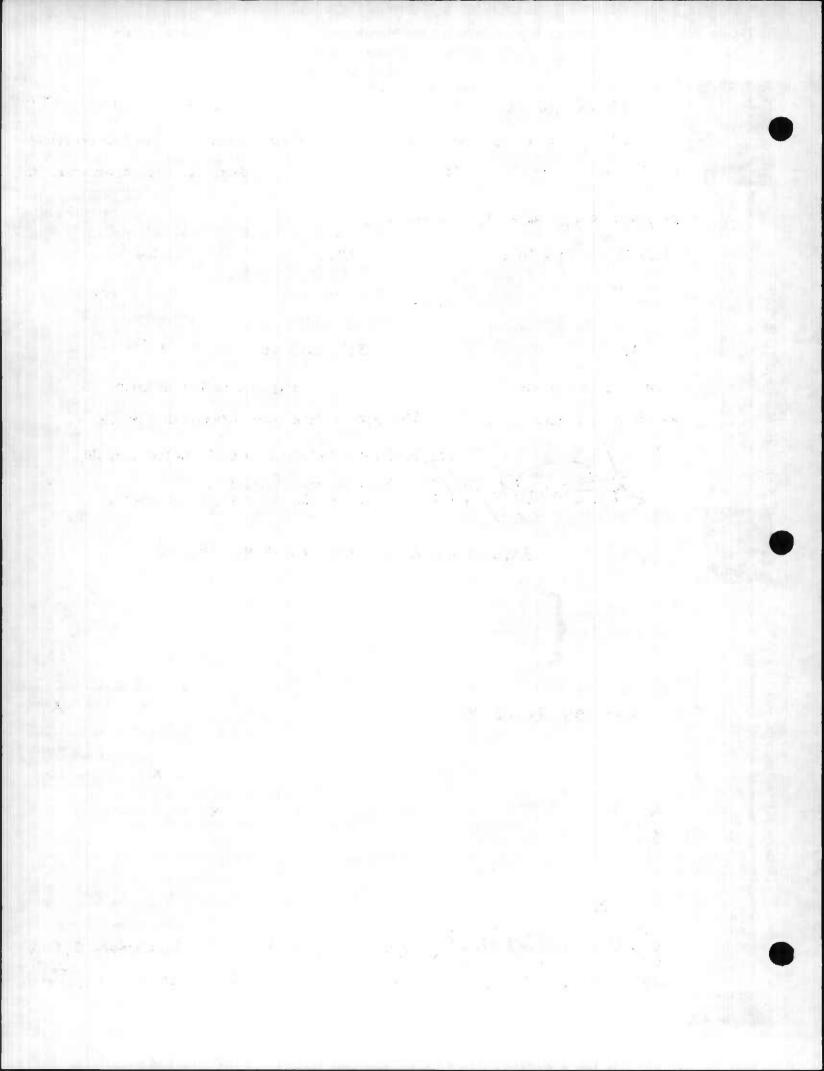
31. Data filad (Month, Day, Year)

SEP 09

32. Registrar's Signatura

within 24 hours at To the Funeral Di completaly filled is Hospital

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dev Month BRTAN KEITH CROCKETT 29,1988 0113 August 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 12 M 2□ F 213-86-5698 September 29,1966 Maryland Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits to Yes 2 □ No Wicomico Maryland Salisbury 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 220 North Blvd 21801 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Salesman Retail Sales 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Phillip Keith Crockett Marcia Linda Burton 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phillip & Linda Crockett/Parents 220 North Blvd., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State Sunnyridge Cemetery 9/1/98 Crisfield, MD 4 □ Donetion & □ Other (Specify) 21. Signifupe of Funeral Service License 22. Name and Address of Facility Holloway Funeral Home 501 Snow H11 Rd, Salisbury, MD 21804 Approximate Interval Between Onset and Death mediate Cause (Final disease or condition resulting in death) 3/11/2 Ġ Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last ence of): au Stano Due to (or as a consi 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ail

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

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Pages 1 and 2 should be nent of Health and Mental

If Item 27

Physician/Medical à Be

the edical Certification: To

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1 Neturel

2 Accident

3 ☐ Suicide

29a. Certifie (Check only one)

4 Homlcide

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

should be det Hospital or Attending Physician: this After after death. Director: A illed in by within 24 hours a

To the Funeral D

completely filled

The law requires that the deeth certificate be executed P.O. Box 68760. Division of Vital Records,

State Registrar

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2110 25. Was case referred to examiner? 1 Yes 2 J N 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work?

26. Place of Deeth (Check only one)

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death? 2 2 No 1 Yes 2 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year)

lan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BENITO

31. Date filed (Month, Day, Year) SEP 0 1 1998 32. Registrar's Signature

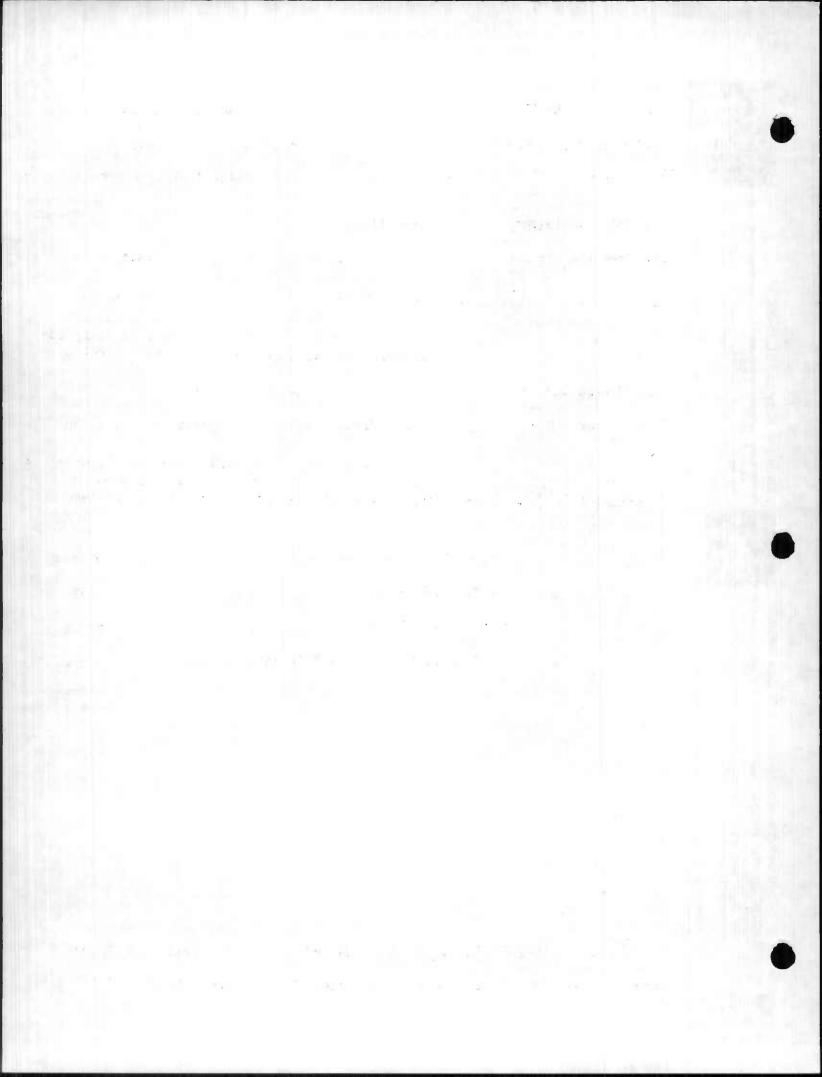
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State	of Maryland / Department of Heal	th and Mental Hygiene	37166
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	Funeral Director	5. Sociel Security Number 217–12–1950		77 Yrs.	Months Deys			y, Yeer)	Cour	place (State or Foreign htry) yland		
	ylend	Usuel Residence of Decedent  10e. Stete 10b. County		10c. City, Town or I	Location				1	10d. Inside City Limits		
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	or 28a-f s be noticed	10e. Street end Number			10f. Zip Code			10g. Citizen of V	What Coul	ntry?		
	23a 23a	1207 Frederick	Street 12. Was Decedent I	Turne in 11 C 40			Specific Veneral News			oan fadion		
0	be filed within 72 hours after death with the Marylend tial Hyglene. d other than "natural", or items 23a or 28a-f show event, the Modical Exertest must be notified.  Be Completed by Funeral Director	11. Marital Status  1 Never Merried 2 Married	Armed Forces?		If Yes, specify Cut	oan, Mexican, Puer	to Rican, etc.)	Bled	ck, White,	etc.		
000	ural', o	3 □Widowed 4 □ Divorced	Year or Dates:						44 11			
15-	- 6	15. Decedent's (Specify only highest		(Giv	edent's Usuel Occu re kind of work done DO NOT use retire	during most of wa	orking					
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	withir To the comp	29b. Signeture and life of certifier	0		29c. Licen	se number		29d. Date signe	d (Month,	Dey, Year)		
		deval	W DiHO	5	D01	062		Septembe	r 9,	1998		
		30. Neme end eddress ot person wh	o completed cause of d	eeth (Item 23a) (Type	e, Print)	100						
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	State Registrar	31. Date tiled (Month, Dey, Year) SEP 1 0 1	- A30	r's Signature	Sport	2						



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State of Maryland / Department of Health and Mental Hygiene 9

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Sa-f show oursed at		nington	Mauga	nsville					1 Yas 2□N
or 2	10e. Street and Number	D ==		10f. Zip Code 217	C 7		10g. Citizan of W U.S		7
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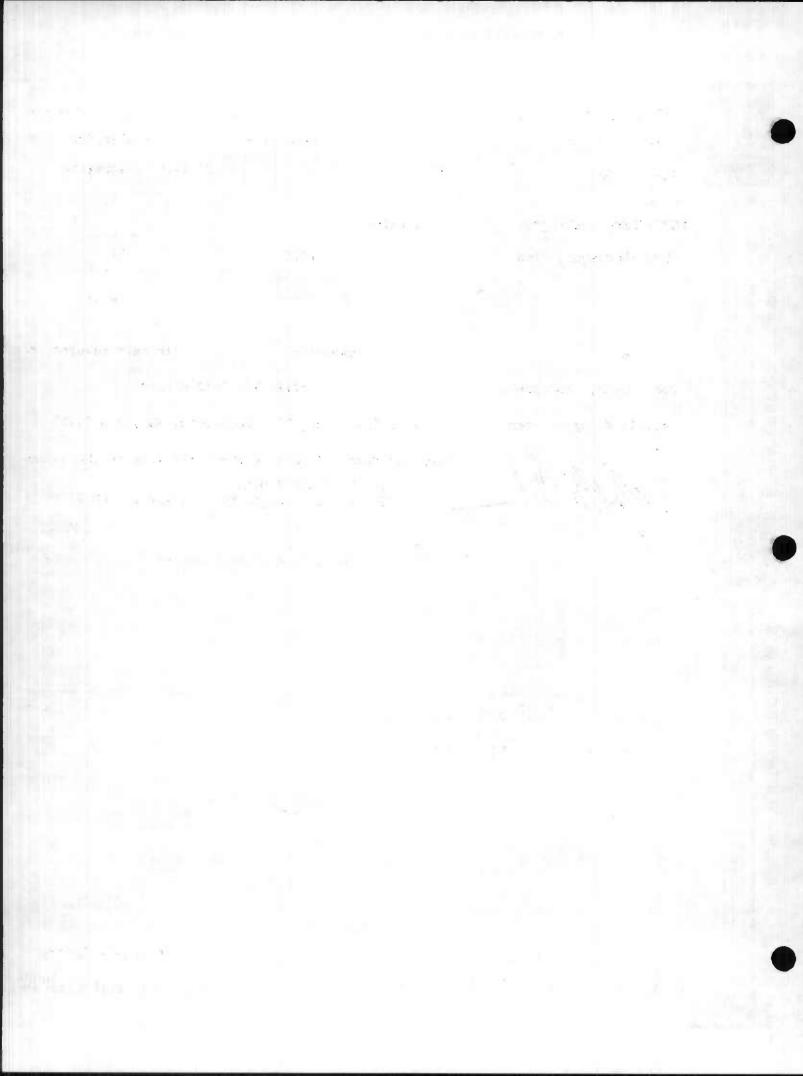
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State of Maryland / Department of Health and Mental Hygiene 9 9971.

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John Henry Marmaduke  19e. Intormant's Name/Reletionship (Type, Print)  Phyllis Kopp/Daughter  7902 Sharpsburg P								
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20e. Method of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Regroyal from State  20b. Place of Disposition (Name of cemetery, cremetory or other place)								ete
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middla, Last) 2 Data of Deeth 3. Time of Death **Physician** Month Kirkland Thomas Cowan 26 21:43 /Medical 4e. Fecility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** JOHNS HOPKINS BAYVIEW MEDICAL CENTER Baltimore BALTIMORE CITY 5. Social Security Number 7. Age (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. 8. Deta of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 18 M 20 F 00 Yrs. None Director 8, 15, 98 00 00 MARYLAND Usual Rasidance of Decedent the Maryland 10e Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Director Franklin Chambersburg 10e. Street end Number 10f. Zin Code 10g. Citizen of Whet Country? 5 items 23a 753 S. Main St. 17201 U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indien, Bleck, White, atc. permit. Pagas 1 and 2 should be filed within 72 hours effar of Department of Health and Mental Hygiene. Important: if fem 27 is marked other than "natural", or free Important: if fem 27 is marked other than "natural", or free any injury or other traumatic event, the Mexical Exercite Annual Space. 1 Naver Merried 2 Marriad Baltimore, Maryland 21215-0020 1□ Yes 2No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorcad White Completed 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) 0 None None 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Chris Stewart Carrie Cowan 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Carrie Cowan/Mother 753 S. Main St. Chambersburg, Pa. 17201 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Dry Run, Pa. Upper Path Valley Cemetery 9/1/98 21. Signature of Funaral Service Licensee 22. Nama and Address of Fecility Zimmerman And Son Funeral Home Inc. Greencastle, Pa. 17225 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not antar the mode of dying, such es cardiac or respiretory errest, shock, or heer failure. List only one cause on each line. Approximete Intervel Between Onsat and Death **Physician** Immediete Ceuse (Finei disaase or condition resulting In deeth) /Medical . PROLONGED HYPOXIA AND METABOLIC ACIDOSIS DAYS Examiner Due to (or es e consequence of): , PULMONARY INTERSTITIAL EMPHYSEMA sician and buriel-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to Immediata cause. Enter Underlying Cause (Diseese or Injury that in itieled events resulting in deeth) Lest Due to (or es e consequence of) P.O. Box 68760. attending physician for use as the burie HYALINE MEMBRANE DISEASE Physician/Medical Due to (or es e consequence of): PREMATURITY 31 WEEKS GESTATION DAYS been signed by the a should be detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Wera autopsy findings avelleble prior to completion of causa of deeth? Completed 24e. Wes an eutopsy performed? paga 2 certificata Division of Vital Hospital or Attanding Physician: funaral director, 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1□ Yes 2 No Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) Certification: To this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 1 Neturel 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.

2 Madical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the ceusa(s) end manner stated. 29e. Certifier Medicai 29b. Signature and title of certifier 29c. I Icansa number 29d. Date signad (Month, Day, Year) 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) MARK O HARRIS MD, JUHNS HOPKINS BATULEW MEDICAL CENTER 31. Dete filed (Month, Day, Year) AUG 3 1 1998 32. Registrar's Signature State oaks Registrar

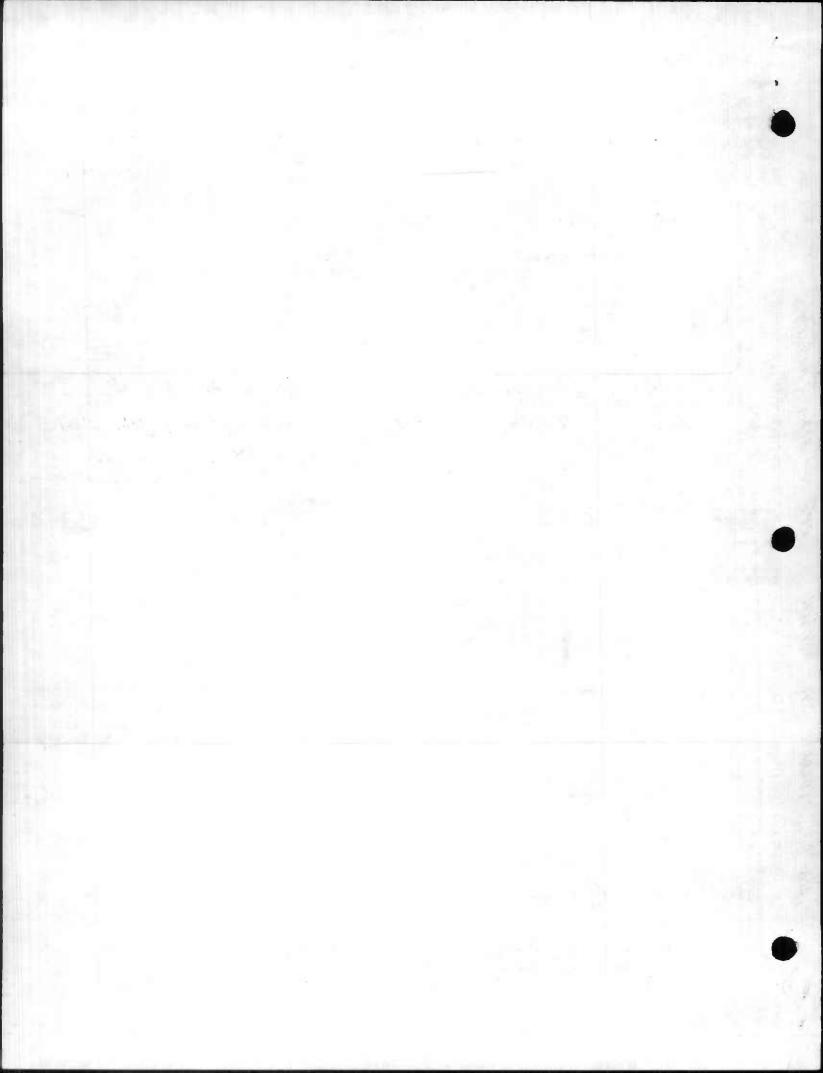
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #7 Per FH Film G763 9-18-98RC Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ANA : - TAGUANA BAIZ-L A. 4a Facility Name (Not institution, give street and number) CEPRLAND ALEXIS 2/25 1998 AUGUST /Medical 4b. City, Town, or Location of Death 4c. County of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 7 Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Funeral Days Min. Hours 1 M 2 D Pez Yrs. 19,1998 None 2 MARYLAND Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f ahow 12 103 2 No Director SAlisbur WICOMICO 10e Street and Number 10f Zin Code 10g. Citizen of What Country? WALNUT STREET 107 2/801 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No HYes, Give Year or Dates: 14. Race - American Indien, Bleck, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 1 Never Merried 2 Married ŏ 1 Yes 2 HO Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry mother Hyglene. Elementery/Secondary (0-12) College (1-4or 5+) Maryland f Heelth end Mental Hy 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be MNthany L. Copeland

19a. Informant's Name/Relationship (Type, Print) ANthanc VALARIR Peges 1 and 2 should nent of Heelth and Men ANN Hudson 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHisbury 1 mothers STREET 107 MALIE A Hudsin Mdi 2/80/ other altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from Stete 三百 permit. Pege Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Hill MEM CEMERE HRBLIN 21. Signature pl.Funeral Service License 22. Name and Address of Facility FUNDEN HOME 50 SALISBUR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Final Prenature disease or condition resulting in death) Examiner Examiner ruptur of nerbrane Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Concarriente Physician/Medical Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 Probably 4 Unknown Vital Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 1 Yes 2 No 1 Tyes 2 No certificate or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA edical Certification: To 1 Yes 20 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation Natural death. 1 Yes 2 No 2 Accident after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 ☐ Homicide To the Hospital of within 24 hours at To the Funerel D completely illed i 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signaturand title of certify 8-20.98 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RODGERS CJ Jalisbury MD PRMC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 1998 Registrar

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1 Decedent's Name (First Middle Last) 2. Date of Deeth Year Month **Physician** JEAN PETTEWAY CLARKE 9 98 12:19 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not Institution, give street and number) Examiner Atlantic General Hospital Worcester Berlin If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Deys Hours Min. 10 M X F Yrs. 244-32-5933 77 7/29/21 NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2€ No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 급 196 Windiammer 21811 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14, Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: white ģ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Operator Telephone Co. 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) George Petteway **Bonnie Austin** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher Clarke/ Son 1050 Broadview Dr. Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cape Henlopen Crematory 9/8/98 Frankford, DE 4 Donation 5 Other (Specify) 22. Neme and Address of Facility Burbage Funeral Home 108 William St. Berlin, MD 21811 the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate tnterval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) Sudden Cardiac Physician/Medical Examine teriosclerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last 23b. Dtd tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Hypertension þ 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? Completed completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 1 ☐ Yes 2 No Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☑ ER/Outpetlent 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be detamined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

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Director:

**Funeral** 

Director

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**Physician** /Medical

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Date,

88 980 To the Hospital of within 24 hours at To the Funeral D completely filled in

29a. Certifier (Check only one)

29b. Signature and title-pf certifier

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

1 critifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 Madtcat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner steted. 29c. License number 29d. Date signed (Month, Day, Year)

Trenderastino 30. Name end address of person who compared ceuse of death (Item 23e) (Type, Print) D30171

Maureen Prendergast, MD 100 E. Carroll St. Salisbury, MD 21801 31. Date filed (Month, Day, Year)

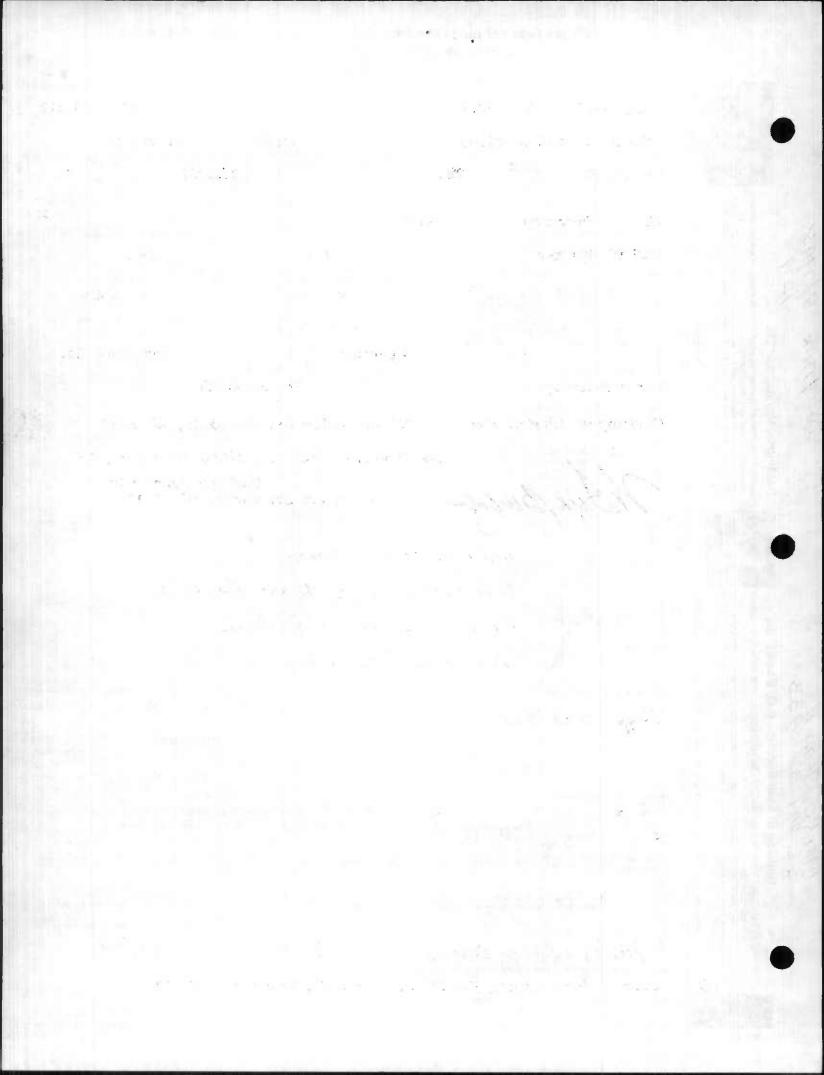
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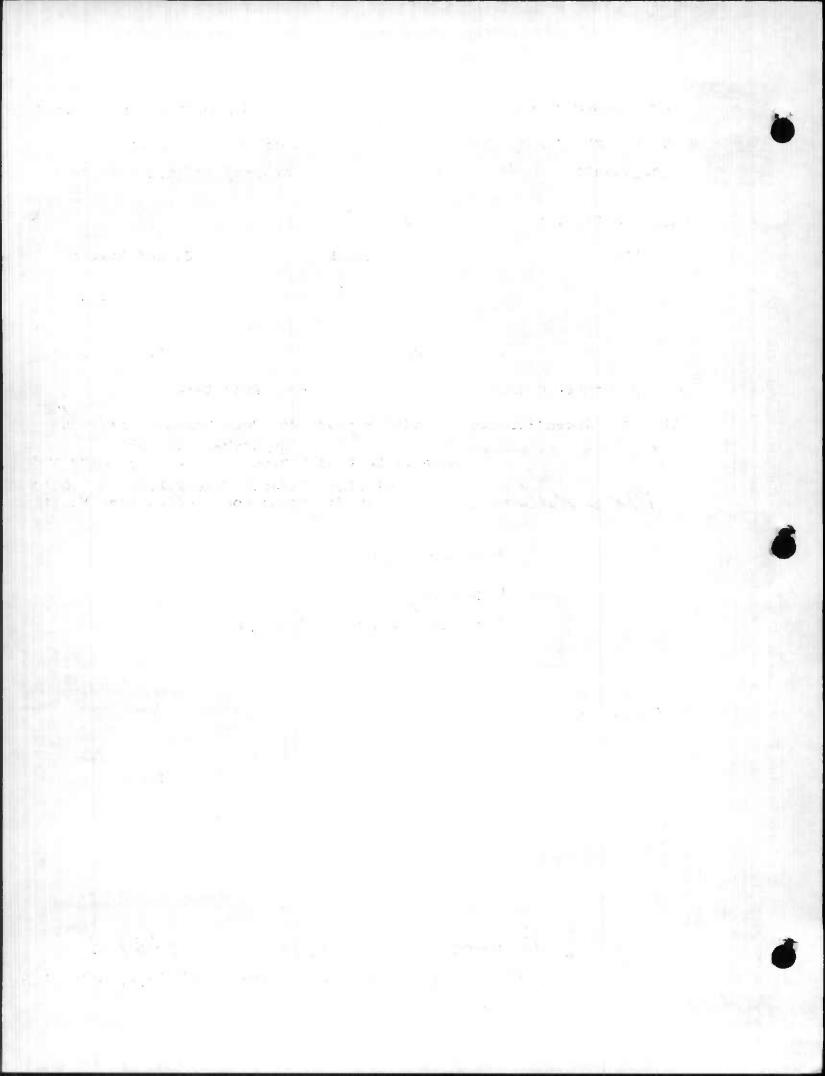
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) Month **Physician** DORA CREED DOANE SEPTEMBER 7 1998 9:00 AM /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner 5070 MARBURY RUN ROAD **MARBURY** CHARLES If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Dey, Year)

January / 14/1906 If Undar 1 Yaar 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 1□M 20F Deys Yrs. 220-30-7432 92 Virginia Director Usuel Residence of Decedent with the Maryland r 28a-f show 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Charles Marbury 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours aftar death with t Department of Health and Mental Hygiena. Important: If item 27 is marked other than "naturel", or items 23s or 2 and hy Injury or other traumatic event, the Medical Example Inval De In once. Box 322 20658 United States Funeral 12. Was Decedant Evar in U,S. Armad Forcas? 1 ☐ Yes 2 ②No If Yes, Give Year or Detas: 14. Race - Amarican Indien 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decadent's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Clerk U.S. Government 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Sumeme) Joseph Jentry Creed Emma Ruth Cain 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20658 19a. Informent's Name/Reletionship (Type, Print) Steven McKeown/Executor 5080 Marbury Run Road Marbury, Maryland 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) September 120c. Location - City or Town, Steta 20e. Method of Disposition 1 XBurial 2 ☐ Cramation 3 ☐ Ramoval from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Marbury Baptist Church Marbury, Maryland 22. Name and Address of Facility
Williams Funeral Home P.A. 21. Signeture of Funeral Service Licensee 20640 illians 4270 Hawthorne Road Indian Head, Maryland 23a. Part1. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediata Causa (Final diseese or condition resulting in deeth) Malnut Examiner Due to (or es e consequence of): Examiner P physician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest provageular d15.2014 Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) use as attending p signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy tindings available prior to completion of cause of death? should should 24e. Wes en eutopsy Completed certificate has t 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No or Attanding Physician: director, 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) To 1 ☐ Yes 2 ☐ ★0 1 Inpatient 2 ER/Outpetient 3 DOA Aftar this funeral 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury et Work? Certification: 1 Naturel
2 Accident 5 Pending 1 Yes 2 No r death. investigation within 24 hours after death To the Funerei Director: / completaly filled in by the f 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homlcide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

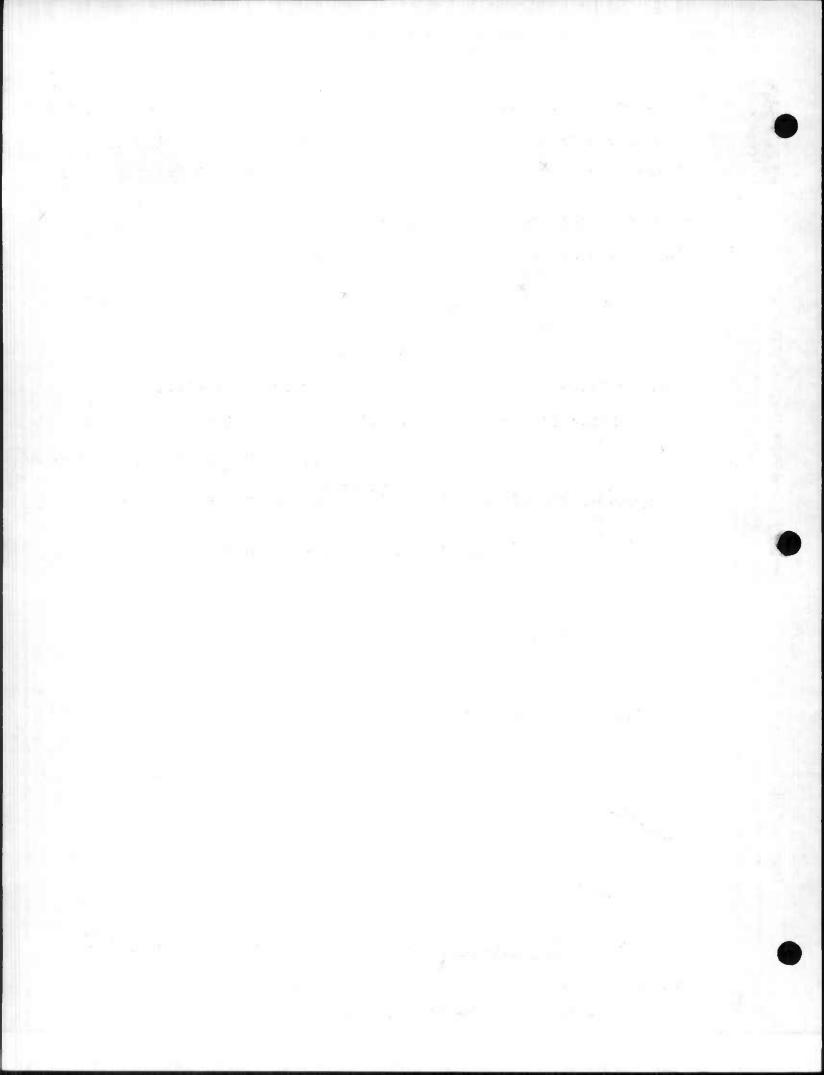
2 Medical Examiner: On the basis of examination and/or investigation, in my coloring, deeth occurred at the time, date and the time date and Medical 29e. Certifier (Check only one) On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Dey, Year) 29b. Signetura end title of certifier 29c. License number 3342 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 90846 Jenkins MD 31. Dete filed (Month, Day, Year) 32. Registrar's Signature 10 1998 SEP Registrar

**DHMH 16 Rev 6/95** 



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

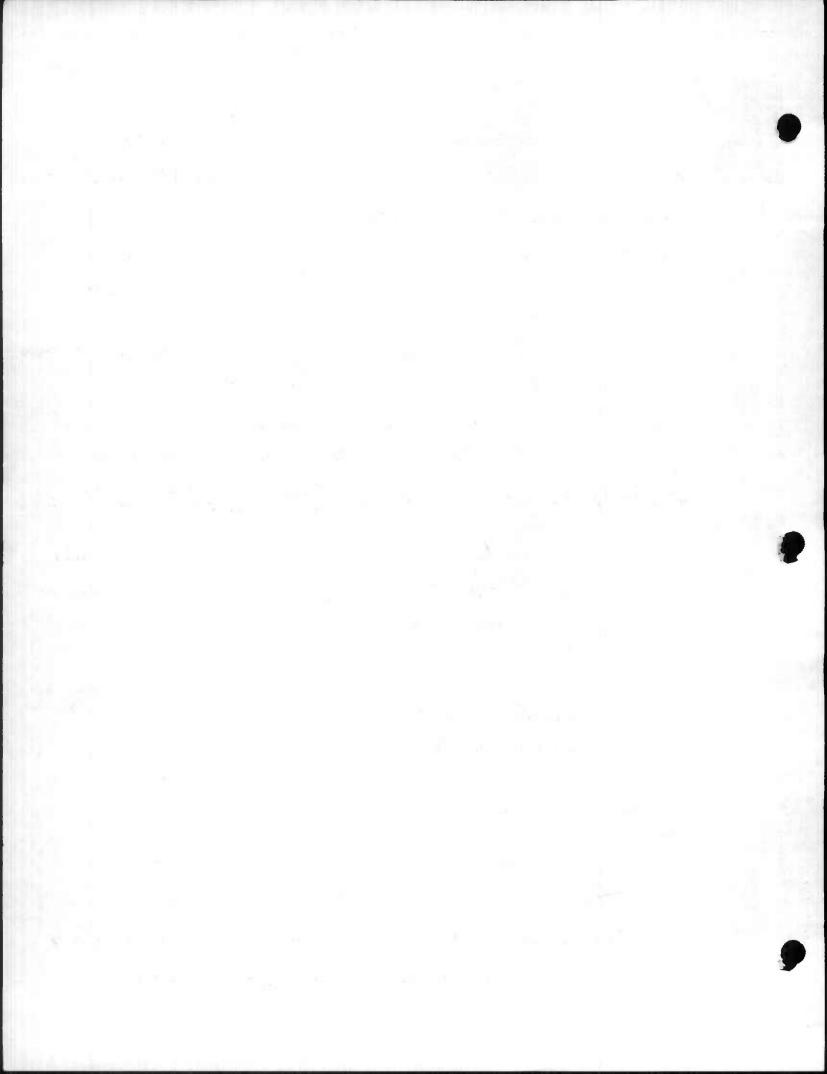
- 6	1 Doordon's Name (First Middle La	-43	Certificate	of Death		eg. No.	20/51
Physician	Decedent's Name (First, Middle, La William James				2. Date of Dear Month Sept. 1	Pay Year 1998	3. Time of Death
/Medical				41. Oh. Taura			6:30 AM
Examiner	4a. Facility Neme (If not Institution, giv	The second secon			r Location of Deeth	4c. County of Deel	
	720 Olivia Str 5. Social Security Number 6. S		last hirthday) If Under 1	Salish		Wicomio	AND THE RESERVE OF THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO I
neral actor		7. Age (In yrs. 60		Deys Hours Mir		1938 Mai	hplace (State or Foreign cyland
one in july or other traumatic event, if which Examine man be not led once.  To Be Completed by Funeral Director	10a. State 10b. County	10c. Cit	ty, Town or Location				10d. Inside City Limits
ō	Maryland Wicom	ico c	oliabu				1 ☐ Yes 2 No
Funeral Directo	10e. Street end Number	100 5	alisbury	Code		Og. Citizen of What Co	
ā	720 Olivia Str	oot			'		out it y r
era	11. Marital Status	12. Was Decedent Evar in U		1801	Specify Vee or No-	U.S.A	ricen Indian
F	1 Never Married 2 Married	Armed Forces? 1XYes 2 □ No	If Yes, specif	nt of Hispanic Origin? ( y Cuban, Mexican, Pue	rto Rican, etc.)	Black, Whit	
by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1956	- 59 1□ Yes 2	No Specify:		Specify: B1	ack
8	15. Decedent's Ed		16a. Decedent's Usual	Occupation		16b. Kind of Business/	
Completed	(Specify only highest gra	de completed)	(Give kind of work life. DO NOT use	done during most of w	orking	755. 74110 07 52011000	dabily
E	Elementery/Secondary (0-12)	College (1-4or 5+)	Labore	r		None	
	17. Father's Neme (First, Middle, Last)			18. Mother's Na	ame (First, Middle, I	Maiden Sumeme)	
To Be	William Cross			1	Doane F	1000	
-	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailing Address (	Street and Number or F			7in Code)
	Larry Fields (			ia Street			
	20e. Method of Disposition	20b. F	Place of Disposition (Name	of		20c. Location - City or	
	1 Burial 2 Cremation 3 C	Memoval from State	emetery, cremetory or other. Marys Ceme		011		
	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Servica Licer			Address of Facility	11218M	est Post	Office, Md
ouce	21. Signature of Furieral Servica Elcer	D. 1.	Stewar	t Funeral	Home		
	Bladys B	Steward	821 We	t Funeral st Rd.Sal	isbury,	4d.21801	
	23a. Part1. Enter the discusse, or com- shock, or heart failure. List only	olications that caused the deet one cause on each line.	h. Do not enter the mode	of dying, such as cardid	ac or respiratory erro	est,	Approximate Intervel Between
n 📗		0 1					Onset and Death
al r	Immediate Cause (Final disease or condition	a vas-	+8111	arcino	oma		2 m65
	resulting in death)	Due to (d	or as a consequence of):				
Examiner		b				i i	
Хал	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events	Due to (c	or as a consequence of):				
	cause. Enter Underlying Ceuse (Disease or Injury	C					
dici	that initiated events resulting in death) Last	Due to (o	r as a consequence of):				
₩		d					
an		d.				-	
Physician/Medical	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying cau	use given in Part f.	23b. Dfd to	bacco use contribute	to the cause of death?
Ph.	Henchie	metases			1 □ Y	s 2□No 3□P	robably 4 Unknown
by	ristani	(11/1/02)			-		
be led					24e. Was a perform	ned?	Were eutopsy findings available prior to
e e							completion of cause of death?
Completed					1 □ Ye	s 2 110	1 ☐ Yes 2 ☐ No
Be	25. Was case referred to medical examiner?			26. Place of De	eath (Check only on	e)	
To	1 Yes 2 1 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DOA	Other: 4 Nursing	Home 5 Deside	nce 6 Other (Spe	cify)
	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of 28	c. Injury at Work?		w injury occurred	
atio	1 Naturel 5 ☐ Pending 2 ☐ Accident Investigation		fnjury M	1 Yes 2 No			
E C	3 ☐ Suicide 6 ☐ Could not be determined	286. Piece of Injury - At he	ome, farm, street, factory,	office		reet end Number or Ru	ırel Route Number,
Certification:	- I nomidue	building, etc. (Specif	y/		City or Towr	, Jiale)	
	29a. Certifier 1 Certifying Ph	yalcfan: To the best of my kno	wiedge, death occurred at	the time, date and pled	e, and due to the ca	use(s) and manner as	stated.
Medical Certification: To	(Check only 2 Medical Examone)	iner: On the basis of examina and menner statad.	tion and/or investigetion, I	my opinion, death occ	urred at the time, de	ate end place, and due	to the ceuse(s)
M	29b. Signature and title of cartifier		29c.	License number	2	9d. Date signed (Monti	
	13.00	2 11-1	m.n	0125	99	9.7-	38
,	30. Neme and address of person who	completed cause of death ("	23a) (Typo Briet)	170 27		( )	
	1-11-11	M ) C / (Item	23e) (Type, Pfint)	71 (0-1			
tata	31. Date filed (Month, Day, Year)	32. Registrar's Signa	sture mal	21801			
State strar	SEP 03		4	pach			
	OLI 00	1000	19	pour			



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

						Cen	tificate	of L		Re	eg. No.	2.0	102
	Physic	ian	Decedent's Name (First, Middle, I							2. Dete of Deet Month	h Dey	Yeer	3. Time of Deeth
	/Medi		William Andrew I	Devine						Septemb	_		0515
3	Exami		4e. Fecility Name (If not institution, g	ive street and numbe	r)			4	b. City, Town, or Lo		4c. County		
			Washington Count	y Hospita	1				Hagerstow	m	Wash	ington	
	Funeral Director		5. Social Security Number 6. 166-07-6335 Usual Residence of Decedent	Sex 7.7	Age (In yrs. lest b 2	irthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, NOV • 1.0	Year)	9. Birthpled	ce (State or Foreign y 1 y 1 y 1
	land		10a. State 10b. County		10c. City, Tox	wn or Loc	ation					10d	l. Inside City Limits
	the Marylan 28a-f show	ō	Maryland Washing	oton	Hage	ersto	พา						ty⊡ Yes 2□ No
	the Market 1	e c	10e. Street end Number	J	1100		10f. Zip C	odo		44	0= Citizan at 1	Affron County	
	23a or	ai Di	26 Garlinger Av	renue				174	0		0g. Citizen of 1	JSA	,
5-0020	or its	by Funeral Director	11. Marital Stetus 1 □ Never Merried 2 □ Married 3 □ Widowed 4 □ Divorced	12. Wes Deceder Armed Forces 1 Types 2 If Yes, Give Yeer or Dates	? ]No WW2		/as Deceder Yes, specity	-	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Ricen, etc.)		ce - American ck, White, etc Whit y:	3.
5-0	"natural",	To Be Completed	15. Decedent's (Specify only highest g	Education	166	e. Decede	edent's Usuel Occupetion e kind of work done during most of w DO NOT use retired)		etion	00	16b. Kind of B	usiness/Indus	stry
2121	C 1 4	pldu	Elementery/Secondery (0-12)	College (1-4o	r 5+)	life. D	O NOT use	retired,	)				
	w be de w	Con				okke	eper			N	Miller Fur		ure Compa
Maryland	d 2 should be filed within the and Mental Hygiene. 7 is marked other than traumatic event, the M	3e (	17. Fether's Name (First, Middle, Las				-		18. Mother's Neme			10)	
/la	should be nd Mental marked o	2	William Patrick	Devine					Mary Agn	es Clear	У		
an	2 sho and ? is ma	ľ	19a. Informent's Name/Relationship	a. Informent's Name/Relationship (Type, Print)  19b. Meiling Address (Street end Number or F								Stete, Zip Co	ode)
Saltimore, M	ages 1 an nt of Heal if Item 2 or other		Catherine B. Dev  20a. Method of Disposition  © Burial 2 Cremation 3  4 Donetion 5 Other (Spec	☐Removel from Stat	20b. Place o	26 Garlinger Avenue Hagerstown  Dete 20  Dete 20				vn, Maryland 21740 20c. Location - City or Town, State agerstown, Maryland			
Ē	semit. Pr Separtme mportant my injury MSB.		21 Figurature of Funerel Service Liq		1		Neme end			7,50	002000	1121	2 7 2 4 1 1 4
Ba	Depa Impo any la		Va nan	12.	ch	Co	sold N	TA	Minnich	305 N.	Potoma	c Stre	et 217/0
	-		23a. Pert1. Enter the disease, or co shock, or heart feilure. List onl	nplications thet caus	ed the death. Do	not enter	r the mode of	of dying	g, such es cardiac o	r respiratory erre	est,	arytan	pproximate
ì	Physician /Medical		Immediate Cause (Final disease or condition		neymon	-							niset end Death
1	Examiner		resulting in deeth)  e									-	2 wks
		ē		1	1	Consequ	ence or):						
	uted ansit	盲		b	many	m	*****					y	nonn
ć	execin and in and inal-tra	Exa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	D	Due to (or es e		ence or):					1	
Box 68760,	The law requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be detached for use as the bunal-transit	an/Medical Examiner	Ceuse (Disease or injury that initiated events resulting in deeth) Lest  Due to (or es e consequence of):  d										
	deat	sicie	Pert II. Other eignificant conditione	contributing to death	but not resulting	In the unc	derivino cau	se aive	n in Pert I.	23b. Did to	bacco use co	ntribute to th	ne cause of death?
P.0	that the ed by th detache	/ Physician/	Drabelise suellipes Cerebrovascular accident								s 2□ No		
Records,	law requires that the death ce les been signed by the ettendir s 2 should be detached for use	Completed by	Cer	ebrovascu	lar acc	cide	uf			24e. Wes er perform		evella	eutopsy findings able prior to eletion of ceuse eth?
	The ate h	00								1 □ Ye	s 25No	1 🗆 Y	'es 2□ No
of Vital	Physician: r this certific rral director,	Be	25. Wes case referred to medical exeminer?						26. Place of Death	(Check only one	e)		
<b>1</b>	yaic is ce dire	2	1 ☐ Yes 25 No	Hospital:	tient 2 ER/O	utpetient	3□ DOA	Othe	r: 4 ☐ Nursing Hor	ne 5 Reside	nce 6 □Oth	er (Specify)	
o uoi	To the Hospital or Attanding Physician: The law within 24 hours effect death.  To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2		27. Manner of Deeth  1 Naturel 5 Pending 2 Accident investigati	28e. Dete of In (Month, D	jury 28b.	Time of Injury		. Injury Work		28d. Describe ho			
Division	or Attar efter des Director I in by th	Certification:	3 Suicide 6 Could not determine	28e. Plece of li building, e	njury - At home, f etc. (Specify)	arm, stree	et, factory, o	office	2	28f. Location (Str City or Town	reet end Num t , Stete)	er or Rurel R	Poute Number,
1	dospital 4 hours uneral ely filled	edical C	Check only > Medical Exa	hysicien: To the bes miner: On the basis	t of my knowledg	e, death o	occurred et	the tim	e, date end plece, e	end due to the ce	euse(s) and me	enner es stete	ed.
	the the l	Med	310)	end menner s	tated.								
	O Twit		29b. Signature enotities of certifier	2	MD				j 4996		Septen	ser 3	y, Year) 1, 1998.
<u>.</u>			30. Name end eddress of person who "ZAFAP MAIK		311 LA	PPAT	us Ry	)	BOOMSBOO	RO M	2171.	3	
	Sta Registr		31. Dete filed (Month, Day, Year) SEP 0 4 19		trar's Signature	G.	Spa	1	,				

DHMH 16 Rev 6/95



•						partment of Fertificate of			Reg. No.	6.5	753	,
Physicia	ın	1. Decedent's Name (First, Middle,						2. Dete of De Month		Yeer	3. Time of	
/Medic	ai		UCILLE		VELB:		4h Cib. Taum	AÜĞÜS		1998	7:00	P.M
Examin	er	4e. Fecility Neme (If not institution, g			- D			or Location of Deet			TON	
Funeral		5. Sociel Security Number 6	Sex 7. A	Age (In yrs. I		if Under 1 Year	if Under 24 H	STOWN Irs. 8. Date of Bir	th WAS		iece (Stete or	
irector		220-09-7495	10 M 20 F	84	Yrs.	Months Deys	Hours M	Irs. 8. Date of Bir Month, De AUGUST	111, 191	4 MA	RYLAND	)
A 11		Usuel Residence of Decedent  10e. State 10b. County		10c. City	, Town or	_ocation				11	0d. inside Cit	v Limits
Examiner must be notified at	to	MARYLAND WASHIN	IGTON	ВО	ONSB	0R0					1 XYes	
enot	Directo	10e. Street end Number				10f. Zip Code			10g. Citizen of	Whet Coun	try?	
Marc	rail	212 MAPLE AVE				217	13		U.S			
1	Funerai	11. Marital Stetus	12. Wes Deceden	5?	5. 13	. Wes Decedent of I If Yes, specify Cub	dispenic Origin? en, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		ce - Americ ck, White,		
	by F	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2X If Yes, Give Yeer or Detes			1 ☐ Yes 2 ☐XNo	Specify:		Specif	y: WI	HITE	
	ted	15. Decedent's (Specify only highest of	Education		16e. Dec	edent's Usuel Occup	petion	undina	16b. Kind of B	usiness/Ind	lustry	
	Completed	Elementery/Secondary (0-12)	College (1-4or	r 5+)		e kind of work done DO NOT use retire	d)	TOTALING	OWN HOME			
		8 17. Fether's Neme (First, Middle, La.	st)		1101	TENAKEN	18 Mother's N	leme (First, Middle				
	To Be	MARKIE OLI		ERFOR	RD		NEL	•	OUISE	•	AFER	
		19e. informent's Name/Relationship	(Type, Print)		19b. Me	ling Address (Street	end Number or	Rural Route Numb	er, City or Town	Stete, Zip	Code)	
		CARL W. RUTHE	RFORD	7		5 BEAVER	CREEK R	1	RSTOWN,	MD.	21740	
		20e. Method of Disposition 1 ☐ Burlal 2 ☐ Cremetion 3		0	emetery, cr	position (Neme of emetory or other ple		Dete	20c. Location			
	-	4 ☐ Donetion 5 ☐ Other (Special Service Lice 21. Signature of Funeral Service Lice 21.		FAJ		V CEMTERY			MERCERSE		PENNS	YLVAN
ouce		21. Signature of Funeral Service Lic	Brady		1	22. Neme end Addre	COFFMAN	FUNERAL	HOME, ]	INC.		
	-	23a. Pert1. Enter the disease, or co	mplicetions that cause	ed the deeth		10 EAST AN				OWN, N	4D. 217 Approximete	
1		23a. Pert1. Enter the disease, or co shock, or heart feilure. List on	y one ceuse on eech	line.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Intervel Betw Onset end D	reen
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	dical	thet initieted events	c. >121	Due to (or		BAENT guence of):	7/4 .			13	years	
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	Physician/M		O			/\						
	ysic	Pert ii. Other significant conditions	contributing to death	but not resu	lting in the	underlylng cause giv	ven in Pert I.	23b. Did	tobacco use co			
i	by Pr			X				_ 10	Yes 2 No	3 Prob	ably 421	Jnknown
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	tlon	27. Manner of Deeth  1 Naturei 5 □ Pending investigeti	28a. Dete of inj (Month, D	ey Year)	28b. Time injury	Wor	yet rk? Yes 2.	144-14-14	how injury occur	rea		
191	E Ca	3 ☐ Sulcide 6 ☐ Could not	he / ( / /	njury - At hor	ne, farm, s	treet, fectory, office	19071	28f. Location (	Street end Numb	er or Rura	Route Numb	<i>961</i> ,
1	Certification:	4 Homicide	building, e	tc. (Specify,	)	n) /1	2	City or Tot	vn, Stete)			
	edical	(Check only 2   Medical Exa	hysician: To the best	of examineti	rledge, dee	th occurred et the tir	ne, dete end ple	ce, end due to the	cause(s) end me	enner es sta	ated.	
	Med	one) 29b. Signeture end title of certifier	end menner s	teted.		29c. Licens						
		200. Signature end title of certifier	9 Mass			-	-8365		29d. Dete signe	i Rg	ody, reer)	
		30. Neme end eddress of person who	completed cause of	dooth (Itam	230) /7		-0.703		-(0)			
		MANZAR	T SHA	PI	26	3 rellL	STRE	ET HA	CERSTO	Scia	MO	
State		31. Date filed (Month, Dey, Year)	20 Pagint	trer's Signet							217/18	7.

Registrar DHMH 16 Rev 6/95

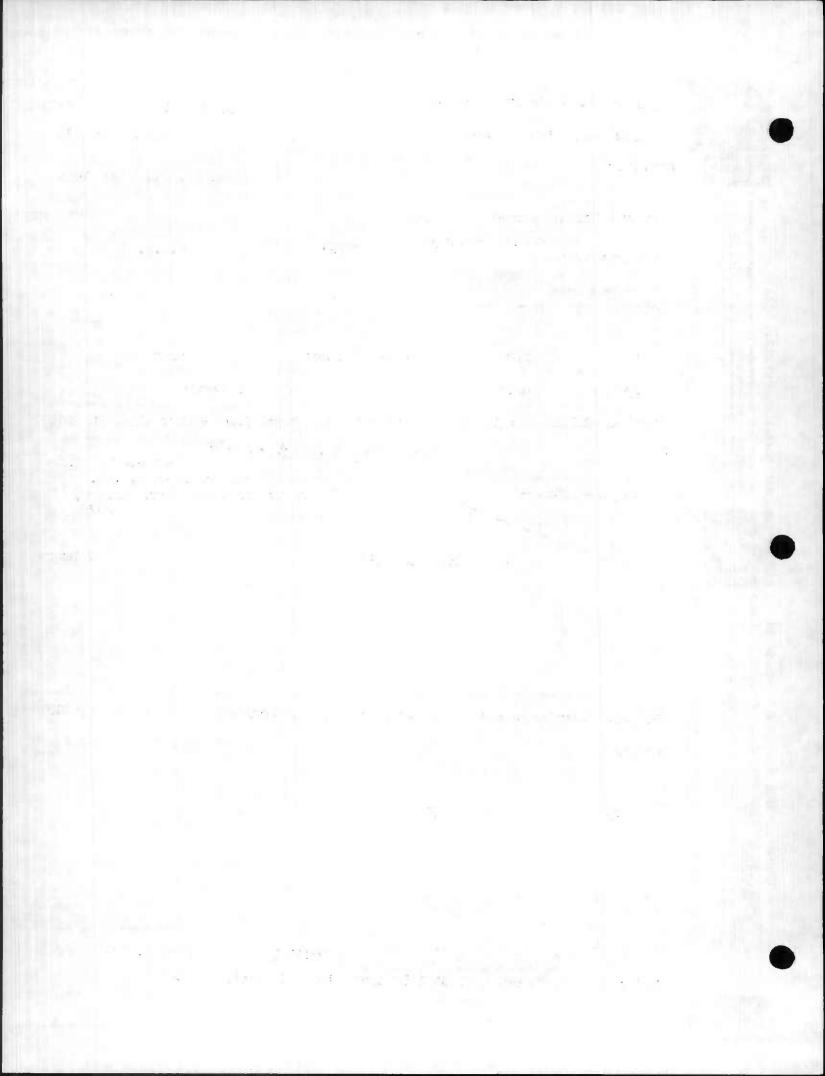
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Date of Death **Physician** Mildred L. Witnauer Fowler 6:00 PM Sept 3, 1998 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner Prince George's Hospital Cheverly Prince George's 7. Age (In yrs. lest birthdey) 84 Yrs. If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 071-07-7710 1 ☐ M 2 💢 F Director June 14,1914 New York Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Magical Examiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Prince George's Largo Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Manor Care with 20774 U.S.A. 600 Largo Road Funeral 72 hours efter death 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status 1 Yes W No If Yes, Give Year or Detes: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 30 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementery/Secondery (0-12) College (1-4or 5+) Hygiene. 12th Retired Clerk Sears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 end 2 should be 1
Department of Health end Mental I:
Important; If item 27 is marked ott
any injury or other traumatic even Be 2 should be fi Enders May McKeque Joseph 2 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Pnint) 6101 Queens Chapel Road Hyattsville, MD 20782 Virginia Willix (Daughter) 20b. Place of Disposition (Name of competent, crematory or other place). Sept. 14<sup>Date</sup> 998 Sylban Abbey Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremetion 3 Removel from State 4 □ Donetion 5 □ Other (Specify) Clearwater Florida 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 proximete Pert1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death 2 Hours Myocardial Infarction Examiner Due to (or as a consequence of): Physician/Medical Examiner that the death certificate be executed ettending physician end for use as the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760, Due to (or es e consequence of): ed by the e 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Seizure Disorder, Hypertension, Cerebro Vascular Accident 1 Vos 2 No 3 Probably XX Unknown signed by t Records, þ The law requires 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed Dementia completion of cause of death? pege 2 certificate has 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To Hospital: 1 ☐ Inpatient 2 ☐ R/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XX Yo this funeral 28e. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Attending ours effer deep. 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Direc completely filled in by 4 Homicide 29a. Certifier 12 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and menner as stated. edical 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) end menner stated. (Check only 29b. Signature a 29c. License number 29d. Date signed (Month, Dey, Year) Sept 4, 1998 D29671 9 30. Name and address of person who completed cause of daath (Item 23a) (Type, Print) S. Reyes, M.D. 6501 Landover Road, Cheverly, Md 20785 Villamor 31. Date filed (Month, Day, Year) 32. Redistrar's Signature back 1998 **SEP 10** Registrar

DHMH 16 Ray 6/95

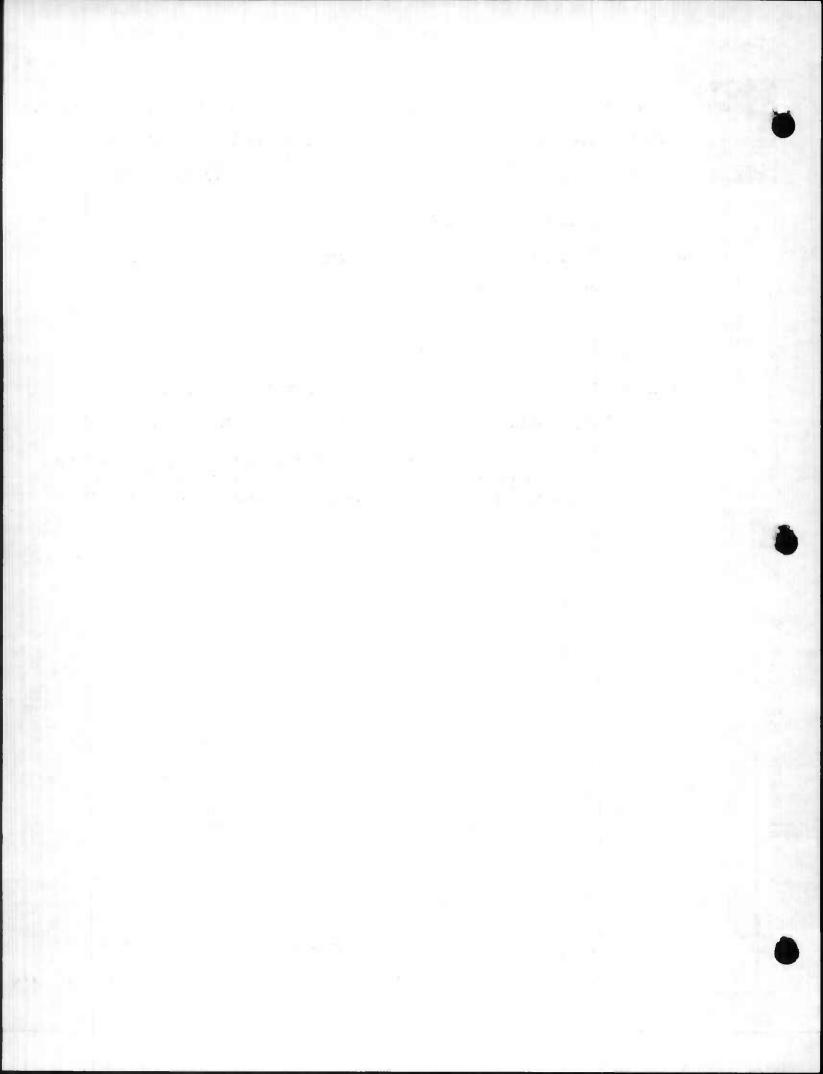


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** CHARLOTTE AUGUST 31 FALES 1998 1:05 P.M. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 4731 MT. BRIAR ROAD KEEDYSVILLE WASHINGTON 7. Age (In yrs. lest birthday) | | Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** 1□ M 2\ F Yrs. 20-28-3721 Director 64 01/16/1934 MARYLAND Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Locetion 10d. Inside City Limits 28a-f show must be notified at 1 Yes 200No Director MARYLAND WASHINGTON KEEDYSVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ö items 23a 4731 MT, BRIAR ROAD 21756 Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: py Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Peges 1 end 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if Item 27 is merked other than "ne any injury or other traumatic event, I'm Media once. 10 YEARS College (1-4or 5+) NURSING ASSISTANT HOSPITAL 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumame) DANIEL G. MUMMA THERESA L. ZIMMERLY 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 4731 MT. BRIAR ROAD, KEEDYSVILLE, MD NEIL L. FALES, HUSBAND 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) BOONSBORO CEMETERY 09/03/1998 BOONSBORO, MARYLAND 21. Signeture of Funerel Service Licensee P. 87 Drufett, Tk 22. Name end Address of Facility 7606 OLD NATIONAL PIKE P. STEVEN DANFELT, JR. BAST FUNERAL HOME BOONSBORO, MARYLAND 21713 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Interval Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final Lung Cance 2 years diseese or condition resulting in death) Examiner Due to (or es e consequenca of): -transit be executed end Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In deeth) Last Due to (or es e consequence of): physician e s the buriel-i Box 68760 Physician/Medical Due to (or es e consequence of): for use es 80 P.O. Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 1 des 2 No 3 Probably 4 Unknown signed l Records, by 24b. Were eutopsy findings eveilable prior to Be Completed 24e. Wes en eutopsy performed? peeu completion of cause of deeth? has page 2 1□ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, it 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Certification: 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide 12 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier Medical (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) P41667 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 1110 Medical Campus fel. Suite 130 Hegerstown MO 28742 Michael J. McCornack 32. Registrer's Signeture 31. Dete filed (Month, Dey, Year) State SEP 0 Registrar



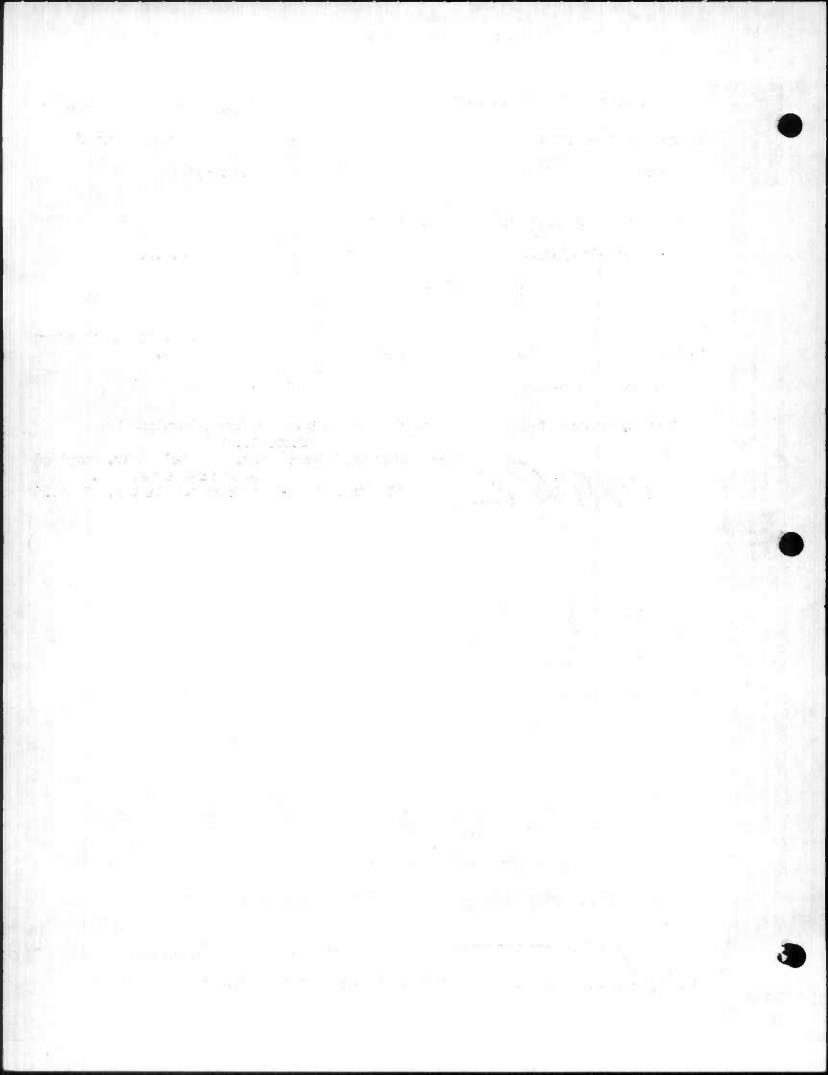
State of Maryland / Department of Health and Mental Hygiene

28756 Certificate of Death 1. Decedent's Nema (First, Middle, Last) Walter Brownhill Gregson 2. Data of Deeth 3. Time of Deeth Dey 1998 Month **Physician** Sept 7, 3:30 AM /Medicai 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care - Largo Largo Prince George's 6. Sex 1 M 2 □ F If Undar 1 Yaar if Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth Month, Day, Aug. 6, 1917 Birthpleca (Stete or Foreign MA) **Funeral** Deys 018-07-8943 81 Yrs. Director Usuel Residence of Decedant the Marylend 10a. State 10b. County 10c. City, Town or Location r 28a-f show show 10d. Insida City Limits 1 Yas ANO Maryland Prince George's Directo Suitland 10e. Street end Numbar 10f. Zip Code 10g. Citizen of Whet Country? with th end Martel Hygiene. 7 is marked other than "naturel", or items 23s or traumatic event, ins Medical Examination. 5016 Suitland Road 20746 U.S.A. Peges 1 and 2 should be filed within 72 hours after death nent of Health end Mantel Hygiene.
Int: If Item 27 is marked other than "naturel; or items 23.
Iny or other traumatic event, the Medical Examinationals. Funeral 12. Wes Decadant Ever in U.S. Armed Forces? 1.0.4 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. 1 □ Yes 2 □ No 1942— If Yes, Give Yaar or Detes: 1946 Black, Whita, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Welfare Department -Elementery/Secondary (0-12) 12th College (1-4or 5+) N/A Clerical MA. 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumeme) Be Wilford Greason Lillian Brownhill 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 5016 Suitland Road Suitland, Maryland 20746 Ruth E. Gregson (Wife) 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) Sept. 10ete 19980c. Location - City or Town, Stete 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removel from Stete permit. Pege Department of Important: If eny Injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) Maryland State Veterans Cem. Cheltenham, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Sen 6633 Old Alexandria Ferry Rd Clinton, MD 20735 23a. Ped.t. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heer feilure. List only one ceuse on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical OF THE WING WITH MEMBRICE Examiner Due to (or es e consequenca of): Examiner MEEKS il or Attending Physician: The law requires that the deeth certificate be executed effect death.

Director: After this certificate has been signed by the ettending physician and in by the funeral director, page 2 should be detached for use es the burlet-transit of in by the funeral director, page 2 should be detached for use es the burlet-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Box 68760, Physician/Medical Dua to (or es e consequança of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 MProbably 4 ☐ Unknown þ 24b. Wera autopsy findings available prior to completion of ceuse of deeth? 24e. Was en eutopsy performed? Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 28. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Dete of tnjury (Month, Dey Year) 27. Mennar of Deeth 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Neturel 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital or within 24 hours eft To the Funeral Di completely filled in 29a. Certifler (Check only one) 15 Certifying Phyelctan: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medicel Examiner: On the basis of axeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end mennar steted. Medical 29b. Signatura and title of certifier 29d. Data signed (Month, Dey, Yeer) D-18545 SEPTEMBER 8, 1998 ul ress of person who completed cause of deeth (Item 23e) (Type, Print)

10. 101. CACKII 12070 Old Line Centre #207 Waldorf, MD 20602 30. Neme end ed 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State SEP 10 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene ()

Mindical   Liste   Hastings   CEHR   Sept. 7   1998   11:31 at   1998   1998   11:31 at   1998   1998   11:31 at   1998   1998   11:31 at   1998   1998   1998   11:31 at   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998   1998		_				Certificate	of Death		leg. No.	1.10 7 0 70				
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The part of the	er, or ite		Completed by	Completed by	**	No			erto Rican, etc.)	Black, White, etc.				
The part of the	P B D				e Completed			16	a. Decedent's Usual	Occupation		16b. Kind of Busine	ass/Industry	
19. Medical Arms Shame (Prise, Mascian States)   19. Medical Arms Shame (Prise, Arms Shame)   19. Medical Arms Shame (Prise, Arms Sham						Elementary/Secondary (0-12)	Collega (1-4or	5+)			rabbeliger			
Ralph Raymond Gehr  19a. Information Name-Palationisting (Type, Print)  19a. Malling Address (Sirelet and Number of Phusi Pacus Number. City or Town, State, Zip Code)  19a. Information Name-Palationisting (Type, Print)  19b. Malling Address (Sirelet and Number of Phusi Pacus Number. City or Town, State, Zip Code)  20b. Method of Disposition  1	C STATE					5	0	0	17. Fathar's Nama (First, Middla, Las	it)				
1 (R Burial 2   Cramation 3   Removal from State   Shanktown   Cemetery   9/10/98   Big Pool, Maryland   21. Signature of Funeral Service Licensee   22. Nama and Address of Feelilly Minnich Funeral Home   415 E. Wilson Blvd.   Hagerstown, Md. 21740   22. Nama and Address of Feelilly Minnich Funeral Home   415 E. Wilson Blvd.   Hagerstown, Md. 21740   Ageroscopy areast, minded and the death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, minded and fine death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, minded and fine death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, minded and fine death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, minded and fine death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, minded and fine death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, minded and fine death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, minded and fine death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, minded and fine death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, minded and fine death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, minded and fine death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, minded and fine death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, minded and fine death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, minded and fine death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, and fine minded and fine death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, and fine minded and fine death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, and fine minded and fine death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, and fine minded and fine death. Do not entar the m	Mantal Mantal Marked on maric ev													
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23a   Pearl Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervit Between thock, or haart failure. List only one cause on each line.   ACHEMIA   TWO WARDS   TWO THE WAR	T to			Domesial from Chat	come	of Disposition (Nama lary, cramatory or oth	arplaca)	Data	20c. Location - City	or Town, Stata				
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23a   Pearl Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervit Between thock, or haart failure. List only one cause on each line.   ACHEMIA   TWO WARDS   TWO THE WAR	erta inju	-	21. Signature of Funeral Sarvice Lice	ensee	· Ditain									
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Sequentially list conditions, if erry, leading to immediate cause. Enter Underlying to medical cause. Enter Underlying to the cent inverse and the cause of death?  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part III. Other significant conditions contributions to the cause of death?	xaminer		rasulting in daath)	a						74				
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The part of the pa	ed by the detache	y 7.11.						1 ☐ Yes 2 ☐ No 3 ☐ Probe						
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30. Name and address of person who gemplated causa of death (Itam 23a) (Type, Print)	Funeral Funeral stely fille dicai C		(Check only 2 Medical Exa	minar on the basis	of axamination a	ga, daath occurred at and/or invastigation, Ir	tha tima, data and place my oplnion, daath oc	ca, and dua to tha courred at tha tima, o	ausa(s) and manna lata and place, and	r as stated. dua to tha cause(s)				
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STEPHUCE MEZNER (M) XC7 WONTHON HUE. THOGGETTOWN /101		3	30. Name and address of person who	emplated causa of	death (Itam 23a	) (Type, Print)	1	. 11	14/	1				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r 2, 1998 **Physician** Month William Abner Grimes September 12:27 a.m. /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 20423 Jefferson Blvd. Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
(Ctober 20, 1932) 5. Social Security Number Birthpleca (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) **Funeral** 18 M 2□ F 220 28 7960 Yrs. Director 65 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. tnside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner multi be notified at 1 Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20423 Jefferson Blvd. 21742 4429 Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces?

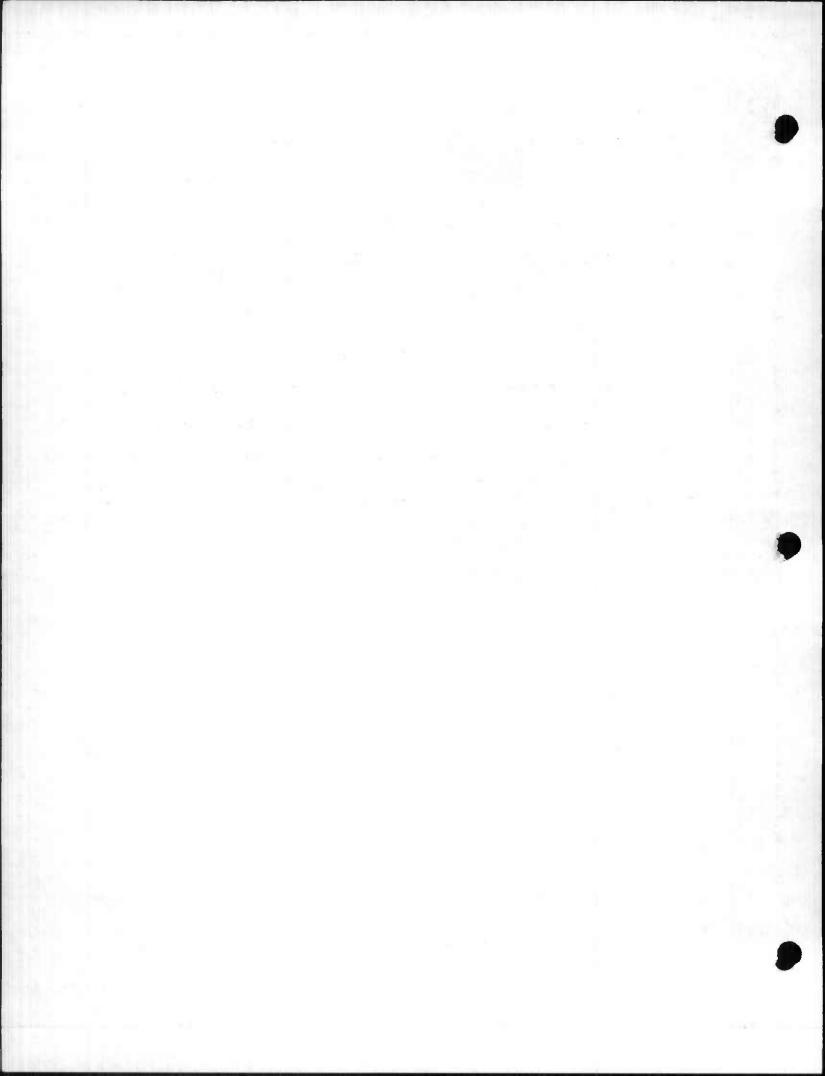
1 ☑ Yes 2 ☐ No If Yes, Give Year or Detes: 53 — 5 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bieck, White, etc. 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2X No Specify: 55 Completed by Specify: white 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry el Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 . Pages 1 and 2 should be filed w tment of Health and Mentel Hygier tant: if item 27 is marked other th lury or other traumatic event, in Supervisor Independent Cement Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Edgar Grimes Frances Vola Crawford 19a. informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Frances E. Grimes Wife 20423 Jefferson Blvd. Hagerstown, Md. 21742 4429 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal trom State permit. Page Department of important: if any injury or once. Rest Haven Cemetery 9/5/98 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Gerald N. Minnich 305 N. Potomac St. Funeral Home Hagerstown, Maryland 234. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. Approximate intervel Between Onset end Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) year Examiner Examiner The law requires that the death certificate be executed the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequença of): P.O. Box 68760. Physician/Medical Due to (or es e consequence of) for use as Part II. Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? cate has been signed by , page 2 should be detect 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 2 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No certificate Hospital or Attanding Physician: funeral director. 25. Was case reterred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4□ Nursing Home 5□ Residenca 6□ Other (Specify) 1☐ Yes 2☑ No Certification: To After this 27. Manner of Death 28a. Date of injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Haturai s after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9.2.98 30. Name end address of person who completed cause ot deeth (item 23e) (Type, Print) Medical Compos Rd. Site 130 the sertown Mo. 11110 McCornacle ). 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State

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Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Month **Physician** Hubert Bradley GUESSFORD August 30, 1998 1300 /Medical 4e. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 1014 Jefferson Boulevard Hagerstown Washington 5. Sociei Security Number If Under 1 Yeer If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Deys Hours Min 1⊠M 2□ F Yrs. 214-16-1457 74 Director Jan. 21, 1924 Maryland Usuei Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours efter death with the Manylan Department of Health end Mentel Hygiene. Important: if Itam 27 is marked other than "natural", or Itama 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be noutled at 10d. Inside City Limits 1 Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1014 Jefferson Boulevard 21742 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: W•W•II 1 □ Never Merried 2 □ Married 1 ☐ Yes 2 ☒ No Specify: white Specify: þ 3 ⊠ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) guard correctional institute 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) unknown Minerva Myers 2 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Ruth Spurdens - caregiver 112 N. Mulberry St., Hagerstown, Md. 21742 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ⊠ Buriai 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 9-4-98 Hagerstown, Maryland Rose Hill Cemetery 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signeture of Funerel Service Licenses 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory strest, shock, or heart feiture. List only one cause on each line. Approximete intervsi Between Onset end Deeth **Physician** /Medical immediate Cause (Final disease or condition resulting in deeth) O. ACUTE MYGCANDIAL INFARCTION SUDDEN Examiner Due to (or es e consequenca of): Examiner BATERIOSCLEROTTE CHADIOVAJEULAR sician end burial-transit DISCHIE XEMOS Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): physician s the burial 99 Physiclan/Medical Due to (or es e consequenca of): 88 esn for ed by the e Pert ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown MELLITUS TURE IL DIASETES þ 8 24b. Were sutopsy findings svailable prior to completion of cause of desth? Completed 24e. Wes sn eutopsy performed? peeu hes 1 Yes 2 9No 1 ☐ Yes 2 ☐ No certificate 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Tyes 2 7 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Date of injury (Month, Dey Year) funeral 27. Menner of Death 28b. Time of 28d. Describe how injury occurred ne Hospital or Attending P n 24 hours efter death. The Funeral Director: After t Certification: 28c. injury et Work? After 1 HNaturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 4 Homicide 29e. Certifie 1 Detrifying Physicisn: To the best of my knowledge, deeth occurred at the time, date and pieca, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end menner steted. (Check only one) within 2. To the F 94 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 001040 08-02-98 -30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

18706 CRESTWOOD DRIVE, HAGENSTOWN, MD, 21742

State Registrar M.

31. Dete filed (Month, Day, Year)

CONON, MD

SEP 0 3 1998

32. Registrer's Signeture

Depen

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene | ? Certificate of Death 2. Date of Death Sept 4, 1998 Heisserman

**Physician** /Medical Examiner

Imogene Eugenia

3. Time of Deeth 11:00 AM

10d. Inside City Limits

White

1 ☐ Yes 2 ☐ No

**Funeral** Director

Director

Funeral

by

Completed

Be

the Maryland ral', or items 23a or 28a-f show Examiner result be notified at with "natural". traumatic svent, the Medical

72 hours after death filed within 7 Hygiene. d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r permit. Pages 1 and 2...
Department of Health ar Important: If Nem 27 is any injury or other trau

**Physician** /Medical Examiner

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

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ed by the attending physician and detached for use as the burial-transit certificate be executed that tha death been signed by the should be detach law requiras paga 2 should this certificata has The Physician: director, funeral To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral

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Records,

Division of Vital

1. Decedent's Name (First, Middle, Last) 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Prince George's Oxon Hill 5101 Wheeler Road If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, Year) March 5, 1 If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months 10 M 20 F Deys 83 1915 Virginia 579 03 8211 Usual Residence of Deceden 10a State 10b. County 10c. City. Town or Location MD P.G. Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5101 Wheeler Road 20745 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, GiveXX Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: 3OWidowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Statistician 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Goode Massey Nuckols Imogen Bowles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10210 Bluff Point Road, Nanjemoy, Maryland 20662 William H. Heisserman, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept 9, P1998 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 Cremation 3 Removel from State Mount Comfort Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityLee Funeral Home, Inc 6633 Old 21. Signeture of Edneral Service Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Finel disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

an

as e consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes an eutopsy performed?

24b. Were autopsy findings aveilable prior to completion of cause of deeth?

Approximate Interval Between Onset and Death

1 Yes 20 No

1 | Yes 2 100

25. Wes case referred to medical examiner? 1 Yes 2 No

5 Pending Investigation

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred 1 Yes 2 No

26. Place of Death (Check only one)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Manner of Death

1 Matural

2 Accident

4 Homicide

3 Suicide

16 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and piece, and due to the cause(s) and mannar as steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

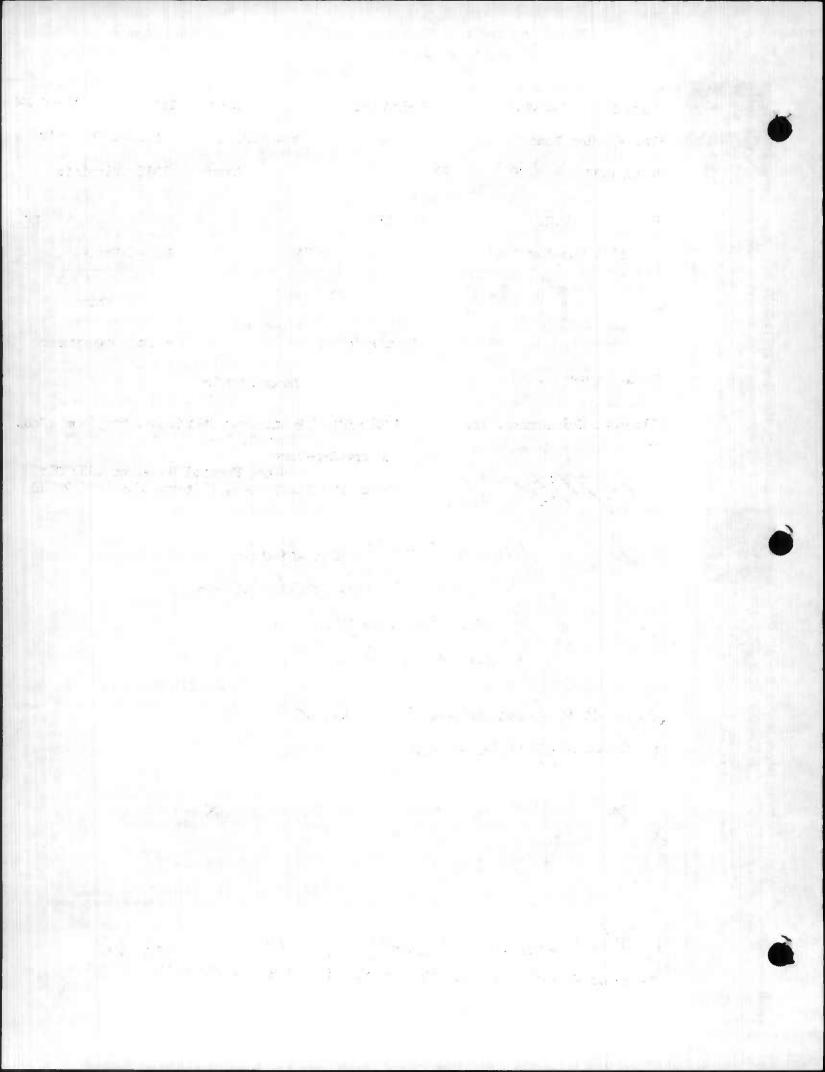
30. Name and address of person who completed cause of death (Item 4902 Temple Hills Road, Temple Hills, Md 20748 Lawrence V. Phillips, M.D.

State Registrar 31. Date filed (Month, Day, Year) 1998 10 SEP

6 Could not be

32. Registrar's Signature

porks



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Sept 7, 1998 **Physician** 2:00 PM James Leo Hill /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not Institution, give street end number) 4c. County of Deeth Examiner 2614 Boones Lane Forestville Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) Aug 6, 1899 9. Birthplace (Stete or Foreign 7. Age (In yrs. last birthday) **Funeral** XXM 2DF Months Days Hours Min. Maryland 99 Yrs. 577 05 0285 Director Usuei Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 Thio r 28a-1 s Director Forestville P.G. MD 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ed other than "natural", or items 23e or event, the Medical Examiner must be r United States 20747 2614 Boones Lane Funeral 12. Was Decedenf Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ Mo If Yes, Give Yaar or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amaricen Indien, Bleck, White, etc. 11. Merital Stetus 1 ☐ Never Married 2 ☐ Married "natural", or 1□ Yes 2□No Specify Specify: White þ ₩idowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) should be filed within Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 4th Repairman Pepco permit. Pages 1 and 2 should be fit.
Department of Health and Mental Hy
important; if Item 27 is merited othe
any injury or other traument. 18. Mother's Name (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middle, Last) A. Quade Margaret William Chapman Hill 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 124 Festone Ave, New Castle, DE 19720 19e. informent's Name/Reletionship (Type, Print) Doris Wharton (DAUGHTER) Baltimore, 20a. Method of Disposition 20b. Piace of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 1 Suriel 2 □ Cremation 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) Cedar Hill Cemetery Sept 11,98 Suitland, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signeture of Funeral Service Licumon Alexandria Ferry Road, Clinton, Maryland 20735 23a. Pert1. Enfar the disease, or complications thef caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset end Death Physician /Medical fmmediate Ceuse (Finel disease or condition resulting in deeth) CARIC MYO PATAY

Due to (or es e consequence of)! GUNAYS Examiner Physician/Medical Examiner ACYTEMYO CAMPL ZLEPRETHEN

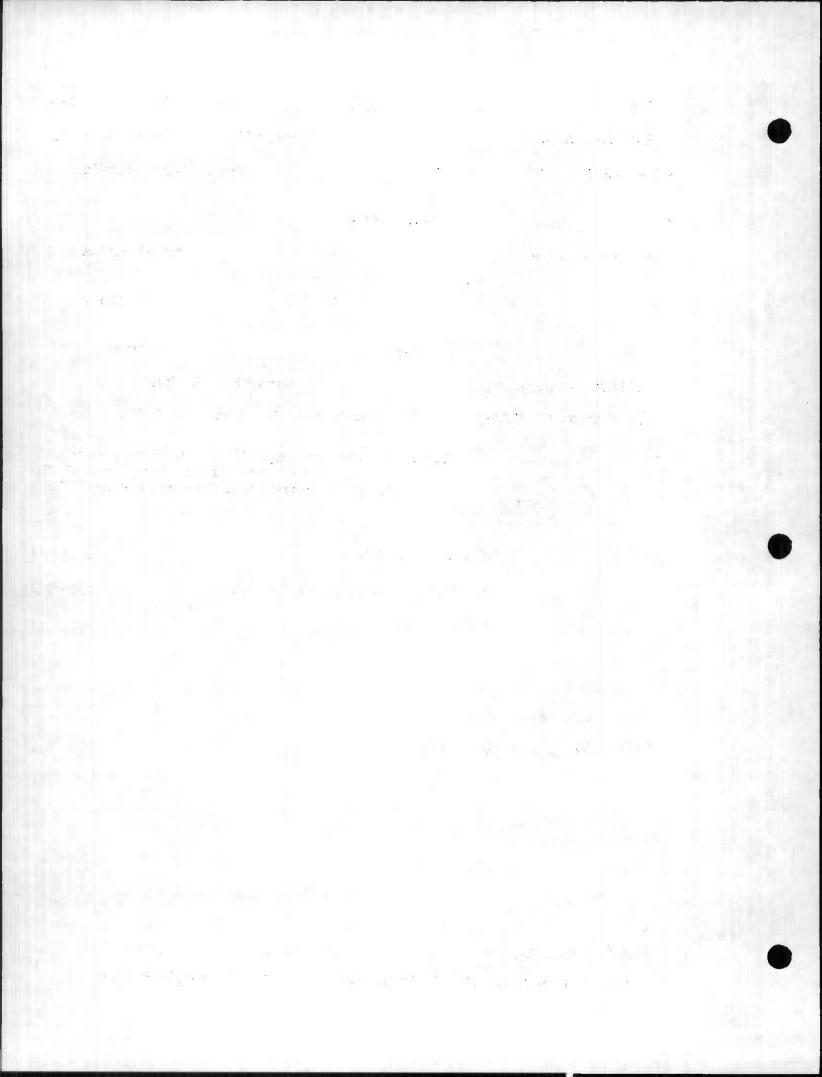
Due to (or es'e consequence of): 600013 The law requires that the death certificate be executed attending physician and for use es the buriel-trans Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 AThenschen 313 YR) Dua to (or es a consequence of): 98 signed by the a d be deteched f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 No 3 Probably 4 Unknown Charice/ pphosic Unkerness þ 24b. Were autopsy findings eveileble prior fo complation of cause of deeth? Completed 24e. Wes en eutopsy PAGE MOKE INSER THEN 1481 hes 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate Physician: 25. Wes cese referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospifai: 1 ☐ Inpatiant 2 ☐ ER/Outpafiant 3 ☐ DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1□ Yas 2□ No Po After this c 27 Manner of Peeth 28d. Describe how injury occurred 28e. Date of Injury (Month, Dey Year) 28b. Time of Certification: 28c. Injury at Work? or Attending 1 Maturel 5 Pending Investigation n 24 hours after death.

Puneral Director: After details in by the fun 1 Tyes 2 □ No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the ceuse(s) end manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end manner stated. 29a. Certifier edical (Check only one) To the I within 2 To the F 29b. Signature end title of certifian 29c. License number 29d. Date signed (Month, Day, Year) 10018013 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) Joseph Caruso, M.D. 7700 Old Branch Ave, D203, Clinton, Maryland 20735 32. Registrer's Signatura State 1998

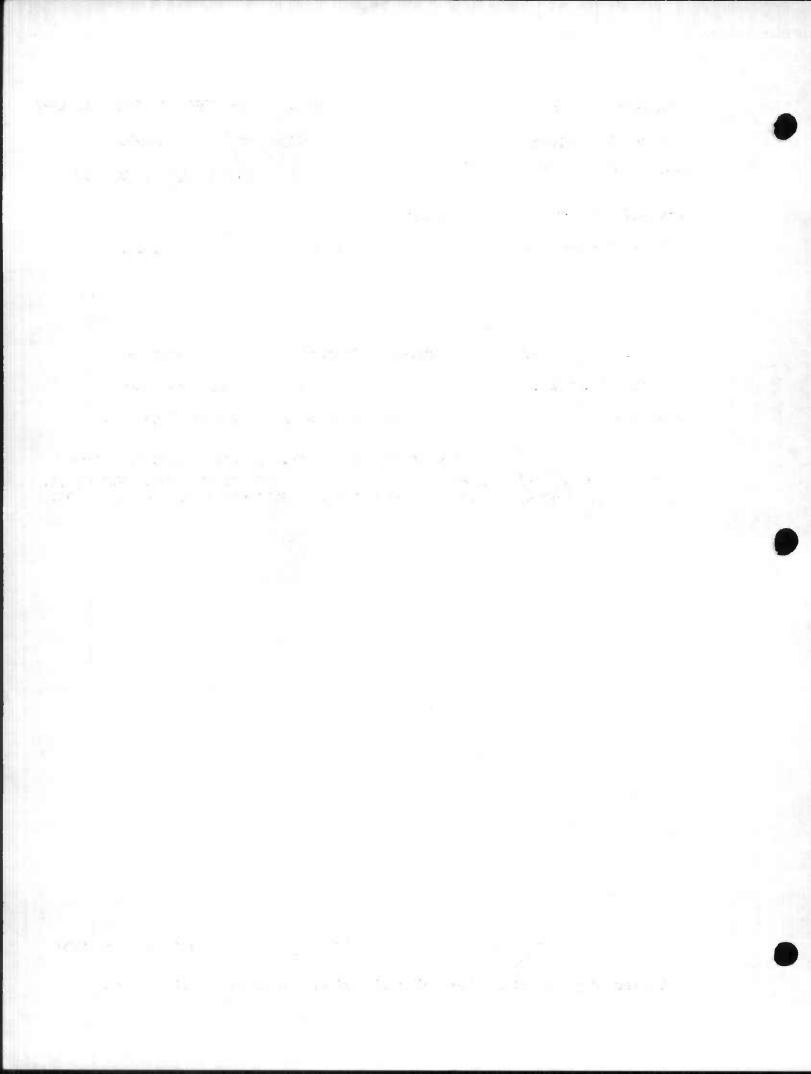
**DHMH 16 Rev 6/95** 

Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Physician SEPTEMBER 3 RICHARD 9:15PM HOOD /Medical 4e. Facility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 13032 SKYVIEW LANE CALVERT LUSBY If Under 1 Yaer It Undar 24 Hrs.
Hours Min. 5. Social Security Number 6. Sax ₩ 2□ F 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Yrs. 579-50-8467 Director March 30,1940 Virginia Usual Rasidance of Decedant deeth with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Insida City Limits 7 is marked other than "natural", or Itams 23a or 28a-f show traumetic event, the Medical Examiner must be notified at Maryland Calvert Lusby Director 1 ☐ Yas 2 ☑ No 10a. Street and Numbar 10f. Zip Code 10g. Citizan of What Country? 13032 Skyview Lane 20657 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 □XYas 2 □ No If Yas, Giva Year or Detas: 11 Marital Status Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effer of Depertment of Heelth and Mental Hygiene. I important: If Item 27 is merked other than "natural", or lien any injury or other traumatic event. In 1 Navar Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) N/A 12th Retail - Grocery Safeway 17. Fsther's Name (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumsma) Be Worley James Hood Cora Lee Moore 19a. Intormant's Name/Reletionship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Ann Hood 13032 Skyview Lane Lusby Maryland 20657 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 XCrametion 3 ☐ Ramovel from Stata Lee Crematory 4 ☐ Donation 5 ☐ Othar (Spacify) Sept. 4, 1998 Clinton, Maryland 22. Nama and Address of Fecility LEE FUNERAL HOME CALVERT, P.A. 21. Signature of Funeral Service Lines see 8125 SOUTHERN MARYLAND BLVD. OWINGS, MD 20736 23a. Part Enter the disease, of complications that arread the flaeth. Do not antar the mode of dying, such as cerdiec or respiretory errest, book, or hash tallure. List only one cause on each line. Approximsta Intarval Between **Physician** LUNG CANCER /Medical Immediata Causa (Final MONTINS disaasa or condition rasulting in daath) Examiner physician and the burial-transit The lew requires that the death certificate be executed Sequantially list conditions, if sny, laading to immediata cousa. Entar Undarlying Cause (Disease or Injury thet initiated avents rasulting in daath) Last Dua to (or ss a consequance of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or es e consequence of): for use as Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobseco use contribute to the cause of death? signed by t 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy tindings svsilabla prior to completion of cause of death? 24e. Was sn autopsy performed? Completed page 2 s 1 ☐ Yas 2 ☐ No certificate Hospital or Attanding Physician: 7 24 hours after death. Funeral Director: After this certifica etely filled in by the funeral director, p 25. Was casa ratarrad to medical axamine? Be 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 0 RO No 1 Yas 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima ot 28c. injury at Work? 28d. Dascribe how Injury occurred Certification: Natural 2 Accidant 5 Panding invastigation 1 ☐ Yes 2 ☐ No 6 Could not be datarmined 3 Sulcida 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify) 4 ☐ Homicida To the Hospital or A within 24 hours effer To the Funeral Direcompletely filled in b 🔂 Certifying Physician: To tha best of my knowladga, daath occurrad st tha tima, data and place, and due to tha cause(s) and msnnar as stated. 29a. Cartifiar Medical (Check only one) 2 Medical Examinar: On the besis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signetura end titla of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) SEPTEMBER 4, 1998 30. Nama and addrass of person who completes causa ot death (Itam 23a) (Type, Print) M.D. 110 Hospital Road Charles Judge, Prince Frederick, Maryland 20678 31. Data flied (Month, Day, Year) 32. Registrar's Signatura State **SEP 10** 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 4b. City, Town, or Location of Death HANSON TRVTN /Medical 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Days 100 M 2□ F 220-44-4262 Director October 19,1912 North CArolina Usual Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d Inside City Limits al', or flerns 23a or 28a-f ahov Examiner must be notified at Delaware Sussex Seaford ₩ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1001 Middleford Rd 19973 USA death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or hen any injury or other traumatic avent, the Medical Essentian page. Bleck, White, etc. 1 Yes 2X No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Medical Physician 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) James Kristian Hanson Cora Betts Wescott 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Hugh K. Hanson/Son P.O. Box 109, Salisbury, MD 21803 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 XCremetion 3 ☐ Removel from Stete 8/29/98 Salisbury, MD Salisbury Crematory 4 Donation 5 Other (Specify) Funeral Service License 22. Name and Address of Fecility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804

M. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Andrew Complete C Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Cereberal Thromberin Examiner Myelodys plastic Significant Traffa o by answer in transformation Physician/Medical Examine physician and the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Empgema þ 24b. Were autopsy findings eveilable prior to completion of cause of death? 24e. Wes an autopsy performed? Dabike Mellitus & newspathy + replace pathy. Completed alternoscleviti Garlesarcular discre à paremaren + mill faile 2 No of Vital 25. Was case referred to medical examiner? edical Certification: To Be 26. Place of Deeth (Check only one) Hospitel: 1 ☑ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury et Work? Division or Attending 5 Pending investigation 1 Divaturel 1 ☐ Yes 2 ☐ No a Funeral Director: A pletely filled in by the fu 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) To the Within 2. 29b. Signeture end title of prtifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and and the of person who completed cause of ceath (Item 23a) (Type, Print) 106 PINEBAUFF Pal Suite 12 SAKBURY Me 2180 JAMES L. CLIPGED ND 31. Date filed (Month, Dey, Year) SEP 0 1 1998

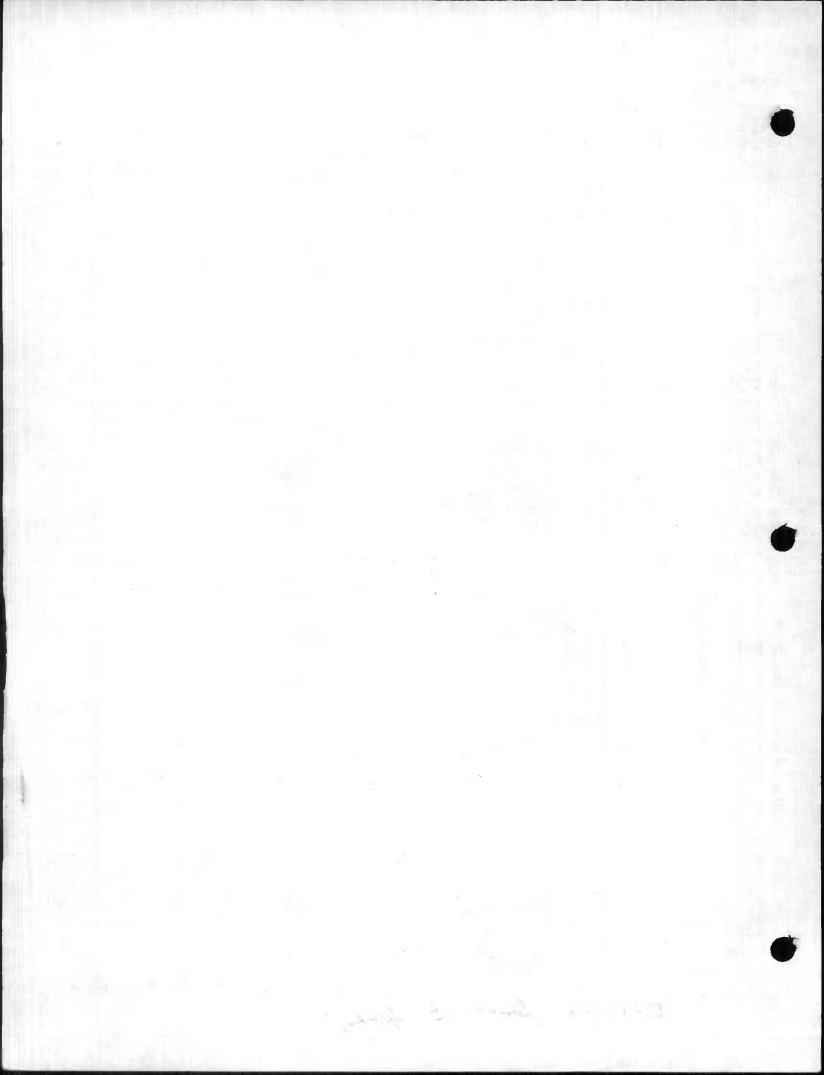
**DHMH 16 Rev 6/95** 

State

Registrar

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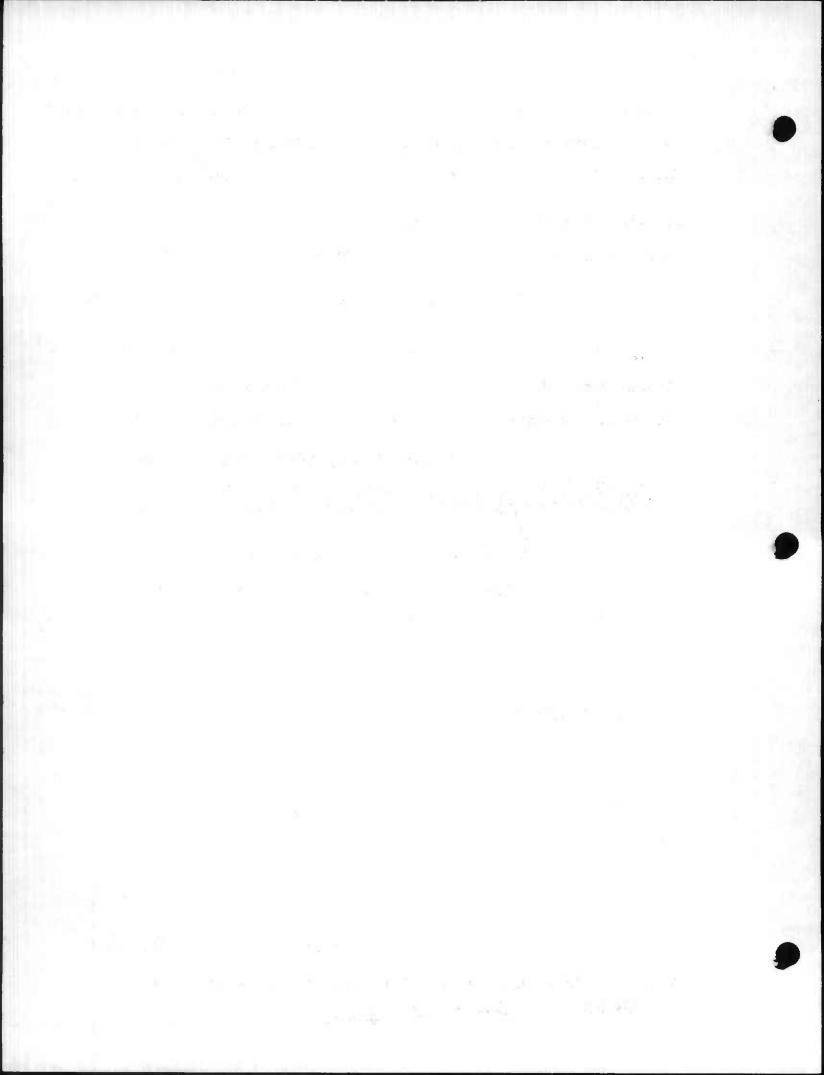
32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene |

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Orville Hearn September 1, 1998 PARKER 4:25 PM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Salisbury Center: Genesis ElderCare Salisbury, MD Wicomico If Under 1 Year If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1X M 2□ F Director 213-14-1481 February 12,1917 Maryland Usuel Residence of Decedent the Maryland Peges 1 and 2 should be filed within 72 hours efter death with the Marylan ment of Health and Mental Hygiene. and the file m 27 is marked other than "natural", or item 23a or 28a-f show ury or other traumatic event, the Modical Exeminer must be notified at units. 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2X No Maryland Directo Wicomico Salisbury 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 510 Douglas Rd. 21801 USA 14. Race - American Indien, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Maritel Status Bleck White etc. 1) X Yes 2 □ No If Yes, Give Yeer or Dates: WW II 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 White à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) Automotive Owner/Operator 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Charles Albert Hearn Clara Belle Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Lottie M. Hearn/Wife 510 Douglas Rd., Salisbury, MD 21801 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete permit. Peges Depertment of Important: If its any Injury or or 1 Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Springhill Memory Gardens 9/4/98 Hebron, MD 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Holloway Funeral Home CFSP 501 Snow Hill Rd., Salisbury, MD 21804 after the mode of dying, such as cardiac or respiretory errest, 23a. Pert1. Enter the disease, or complication, that caused the death. Do not enter shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between **Physician** immediete Cause (Finel diseese or condition resulting in death) /Medical Examiner Examiner sician and bunal-trensit Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Ceuse (Disease or Injury Box 68760. ettending physician for use as the buna Physician/Medical that initieted events resulting in deeth) Lest P.O. Pert II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings evelleble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? Division of Vital 25. Wes cese referred to medicel exeminer? 26. Plece of Deeth (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menner of Deeth 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dev Year) 28b. Time of Certification: 28c. Injury et Work? ne Hospital or Attending P n 24 hours efter death. In Funeral Director: After t After 5 Pending investigation 1 Naturel 1 Tyes 2 No 2 Accident 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner stated. Medical 29a. Certifier (Check only one) Within 2 29d. Dete signed (Month, Dey, Yeer) 29b. Signeture end title of comfier 29c. License number 00 -10 D 39813 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Michael R. Atkins, M.D. 1104 Healthway Dr., Salisbury, MD 21804 32 Registrer's Signature Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death September Day, 1998 **Physician** 2:24 AM Dorothy Virginia Hemphill /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Avalon Manor Nursing Home Washington Hagerstown 7. Age (In yrs. lest birthday)

1 Under 1 Yeer If Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign Country)
Mary Land **Funeral** Deys 1□ M 20 F 220-26-5451 67 Yrs. **Director** Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at 1 X Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 West Baltimore Street 21740 USA Funeral "natural", or items 12. Was Decedent Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours effer.
Department of Health end Mentel Hygiene.
Important: If Itam 27 le merked other than "natural", or fler
eny injury or other traumatic event. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Publishing Technician Publishing Company 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surneme) Be Walter May Mary Borgman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles R. Sharer/Nephew 11801 Clearview Road, Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State Cedar Lawn Memorial ParkSept.10,1998 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 23a. Perfl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart frilure. List only one cause on each line. 1331 Eastern Blvd., N.-Hagerstown, Maryland 21742 **Physician** Immediate Cause (Finel diseese or condition resulting in death) /Medical carcinomo him him with metantani 10 met Examiner Due to (or es a consequence of): Examiner physician and s the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): 80 use ò P.O. Part II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? Dietat Malletin peen has page 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No of the death.

Director: After this certification Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ InpatIent 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 -No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 | Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide n 24 hours e filled Hospital 29a. Certifier Medical 1 🕒 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) end manner stated. within 2 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) tratt mo D (8019 Sept > 1997 30. Neme end address of person who completed ceuse of death (Item 23a) (Type, Print) Vasant Datta, MD-334 Mill Street Hagerstown Maryland 21740 31. Date filed (Month, Day, Year)

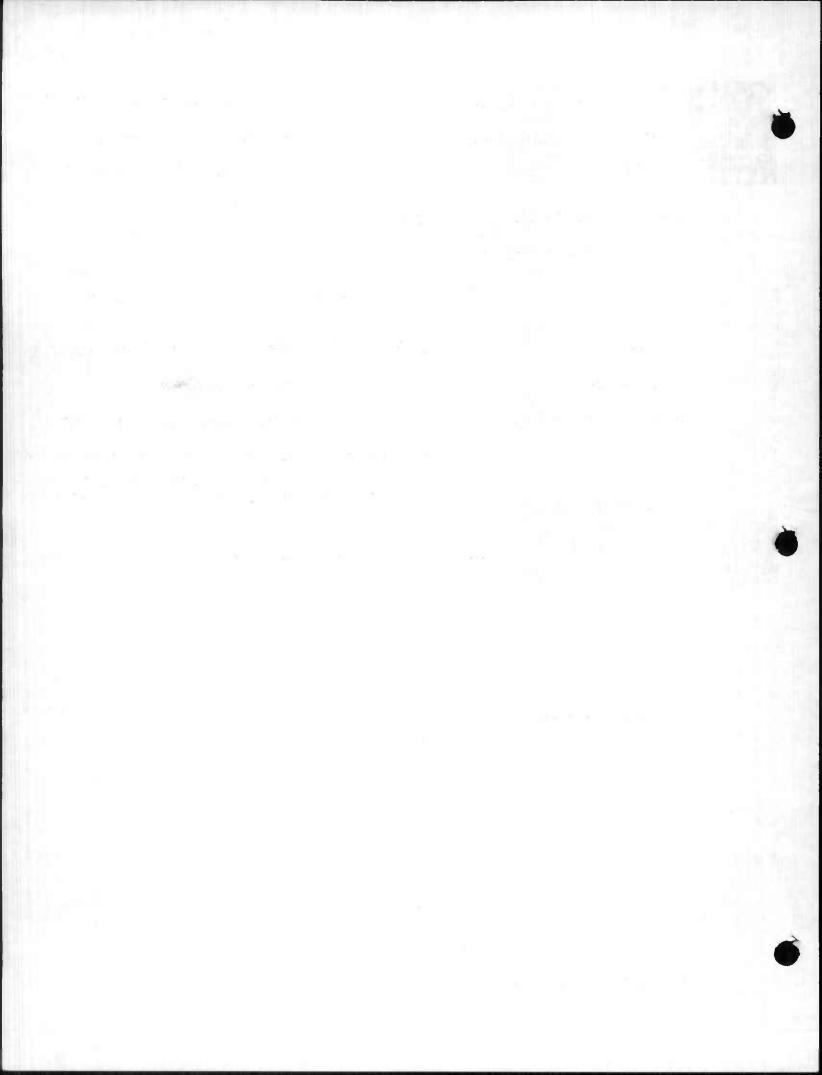
32. Registrar's Signature

SEP 0 9 1998

**DHMH 16 Rev 6/95** 

State

Registrar

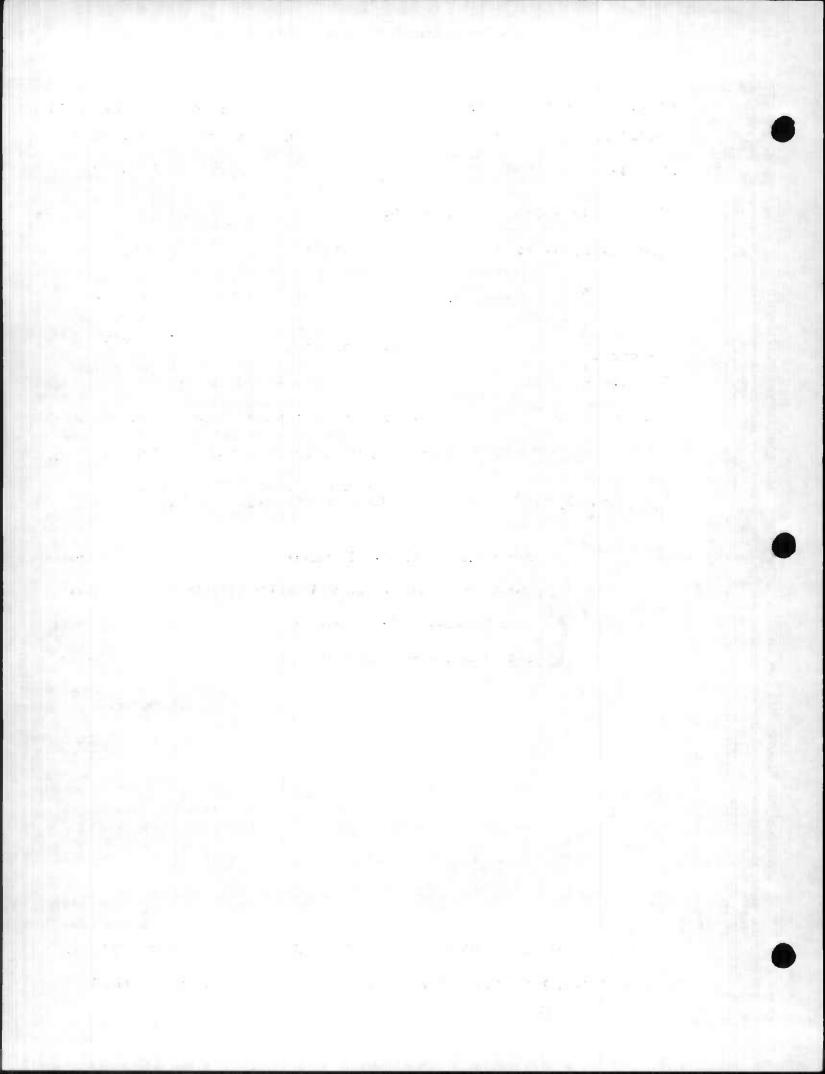


State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Day Yaer Month **Physician** EDWIN RUDOL PH HIII.I. 29, 1998 8:30 AM August /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 14702 National Pike Clear Spring, Washington If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) April 5, If Under 1 Yaar Birthplace (State or Foreign Country) 5. Social Sacurity Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 10 M 2□ F 75 214-14-6841 Yrs. 1923 **Director** Usual Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or frame 23a or 28a-f show coloni Examiner must be notified at MD Washington Clear Spring 1 Yas 2 No Director 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code with 14702 National Pike 21711 U.S.A. Funeral death Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Raca - Amarican Indien, 12. Was Dacadant Ever in U,S. Armed Forces? 11. Marital Stetus Bleck, White, etc. d 2 should be filed within 72 hours after th end Mentel Hygiene. 7 le marked other than "natural", or fle treumatic event, or Medical Examina 1X Yas 2 □ No If Yes, Give Yeer or Detes: 1 ☐ Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2□No Specify: White WWII Specify: White þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry railroad Elementary/Secondary (0-12) Cottege (1-4or 5+) car inspector 10 years 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) . Pages 1 end 2 should be fill ment of Health end Mentel Heant: If Item 27 is marked oth jury or other treumatic even Be Francis P. Hull Olive Carbaugh 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14702 National Pike Clear Spring, MD 21722 Louise Hull 20b. Piece of Disposition (Neme of 20c. Location - City or Town, State 20e. Method of Disposition Dete Rose Hill Cem. Sept.1, 1998 1 Buriel 2 Cremetion 3 Removal from State permit. Page Depertment of Important: If any Injury or pace. Clear Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Thompson Funeral Home, Inc. P.O.Box 310 Clear Spring, MD 21722 leuges 23a/Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respit shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finei Acute and Chronic Renal Failure diseese or condition resulting in deeth) 6 months Examiner Due to (or as e consequence of): Examiner Due to Hypertensive Cardio Vascular Disease vears The law requires that the death certificate be executed physicien and s the buriel-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest Due to (or es e consequence of). Division of Vital Records, P.O. Box 68760, and Diabetes Mellitus Type II years Physician/Medical Due to (or as e consequence of): for use es and Adenocarcinoma prostate years signed by the e Pert II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributs to the cause of death? 1 Tas 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to been si 24a. Wes an autopsy Completed completion of cause of deeth? s certificate has b 1 ☐ Yes 2X ☐XVo 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was cese referred to medicel examiner? 26. Plece of Deeth (Check only one) Be Other: 4 ☐ Nursing Home 5 🛱 Residence 6 ☐ Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funerai Certification: 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1XXXaturel 5 Pending death. 1 Yes 2 No Investigation 2 Accident ofter death Director: / 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29a. Certifier \*\*Exertifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) and menner es steted. edicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end manner stated. 29c. Licansa number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier au XX XVIII D01062 August 31, 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edward W. Ditto, III, M.D. 217 W. Washington St. Hagerstown, MD 31. Date filed (Month, Dey, Year) SEP 02 1998

32. Registrar's Signature

Darks

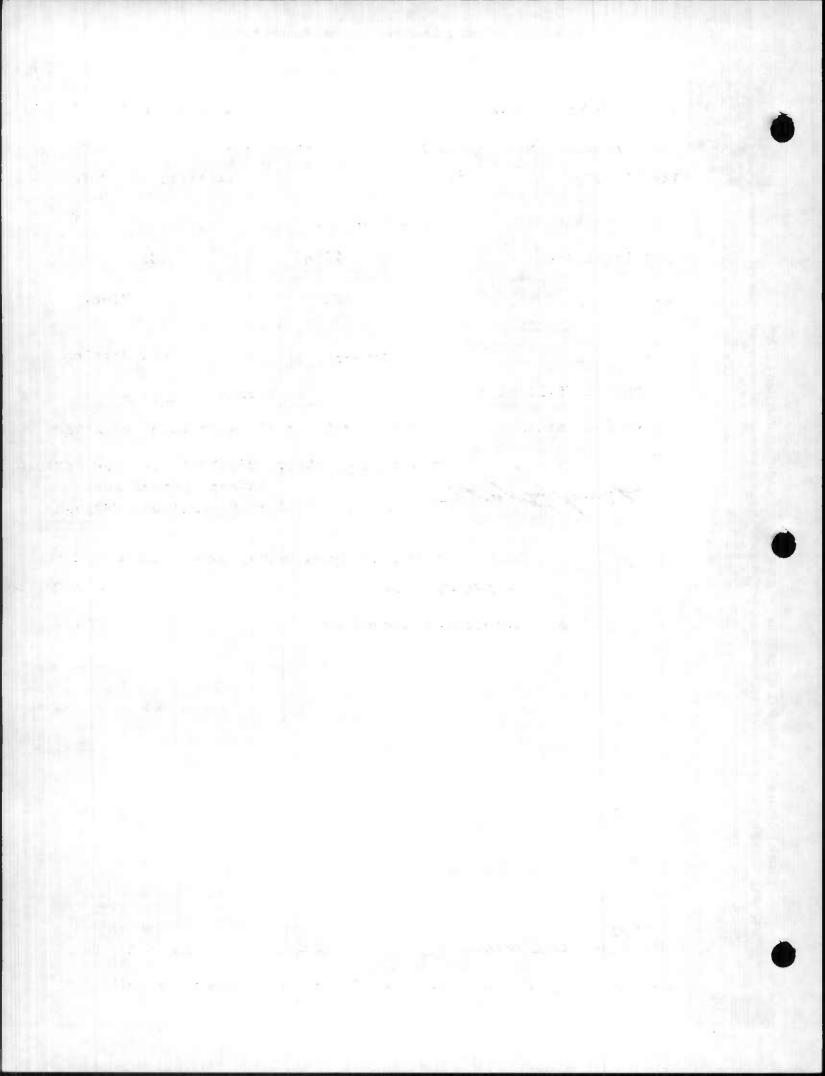
Registrar



State of Maryland / Department of Health and Mental Hygiene

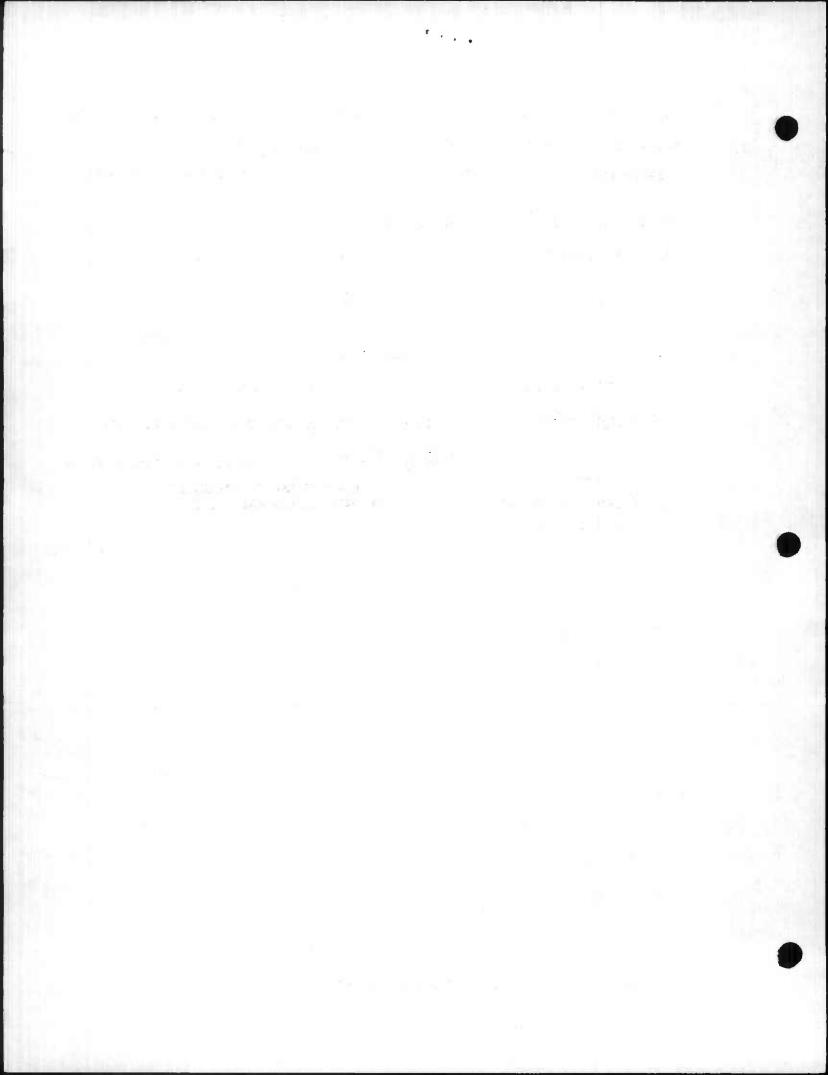
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State of Maryland / Department of Health and Mental Hygiene

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72 hours after death with the Manylend natural; or items 23s or 28s-f show	Funerai	11. Maritai Status	ENUL	-	nt Ever in I	10 121			lionanio Oriole	o2 (Casaib, Vas	USA		e - Amarica	n Indian
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I', or	by	3 Widowed 4 □ Divord		If Yas, Giva Yaar or Date			1□ Yas	2X No	Specify:			Specify	WHIT	ਸਾ
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s 1 and 2 should be filed within 72 hr I Health and Mental hygjene. tem 27 is marked other than "natur other traumailc event, if a Medical	BeC	17. Father's Nama (First, Midd	le, Last)						18. Mothar's	s Nama (First, M	iddla, Maid	a <i>n Sum</i> am	e)	
Aental Aental rked o	ToE	WILME	RTI	NGLE		MARY ELLEN TRUITT								
2 should be end Mental is merked o aumetic eve		19a. informant's Name/Raletic	nship (T	ype, Print)		19b. Meilir	ng Addrass	(Straat	and Numbar	or Rural Route N	umber, Cit	y or Town,	Stata, Zip (	Coda)
1 end 2 Health e em 27 is		SON-IN-LAW	D S. ATKINSON/						,MD. 21842		<b>)</b>			
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Pages nent of I nt: If ite		1 X Buriai 2 ☐ Cramatic 4 ☐ Donation 5 ☐ Other			nta DAG	SBORO CONTROL CONTROL	REDME	NS	,0,	0/8/0	8 DAC	CRADA	, DELA	LIADE
permit. Pag Depertment Important: i any Injury o		21. Significan Quantal Super		100 # 901	PIEP				ss of Facility	9/0/9	O DAG	DIORC	, DELE	IWARE
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/Medical		immediata Cause (Final			500	752	2							20043
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	Je.					or as a conseq	uanca or):	2	The state of the s	}			1	
death certificate be executed e ettending physician end of for use es the bunal-transit	Examiner	Cognantially list conditions		b. Swo Strage / Linewill  Due to (or as a consaquanca of):										
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law requires thet the as been signed by th 2 should be detache	Completed									_	performed?		com	pletion of causa eeth?
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Phy or this	-	27. Manner of Death		28a. Data of i	njury	28b. Tima of		8c. Injur			ribe how In			
ding it th. After funer	tio	1 Naturai 5 □ Pan 2 □ Accidant Inva	ding stigation	(Month,	Day Year)	Injury	М		k? Yas 2⊡No	,	250. December now injury coolaired			
I or Attanding after death. Diractor: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Cou	d nof be	28a. Placa of	Injury - At h	oma, farm, str	aat, factory	, office		28f. Locat	ion (Straat	and Numb	ar or Aural	Route Number,
afte Dira d in t	ert	4 Homlcida  datarmined  datarmined  28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)								City o	r Town, Sta	ata)		
Hospital 24 hours Funaral stely filled		29a. Cartifier 1 ☐ Cartif	Ing Phy	aiclan: To tha be	st of my kno	wledga, daath	occurred	at tha fin	na. date and r	place, and dua to	tha causa	(s) and ma	nnar as sta	ited.
To the Hospital or At within 24 hours after of To the Funaral Diract completely filled in by	edicai	(Check only 2 Medic	al Exami	nar: On the basis and manner	of examina	tion and/or Inv	astigation,	In my o	pinlon, death	occurred at tha t	ima, data a	nd placa,	and due to t	he cause(s)
within 2 To the	Me	29b. Signatura and fitter of certi	fiar				290	. Licans	a number		29d. [	Data signe	d (Month, D	ay, Year)
->-0		) ///x	109	11	10			D 20	012			7/4	199	3
		30 Name and address of re-	in toba			n 22a\ /T		D 39	013			1 / 1	,	
	2	30. Name end eddress of personal Michael R. A						. D.	0-1	d alasses	M	11001		
- 01		31. Dete filed (Month, Day, Ye			strar's Signa		LUIWay	y Dr	., sal	isbury,	MD &	21804		
Sta Registr		CED ()			merca	<b>1</b> .	10	ack	2					

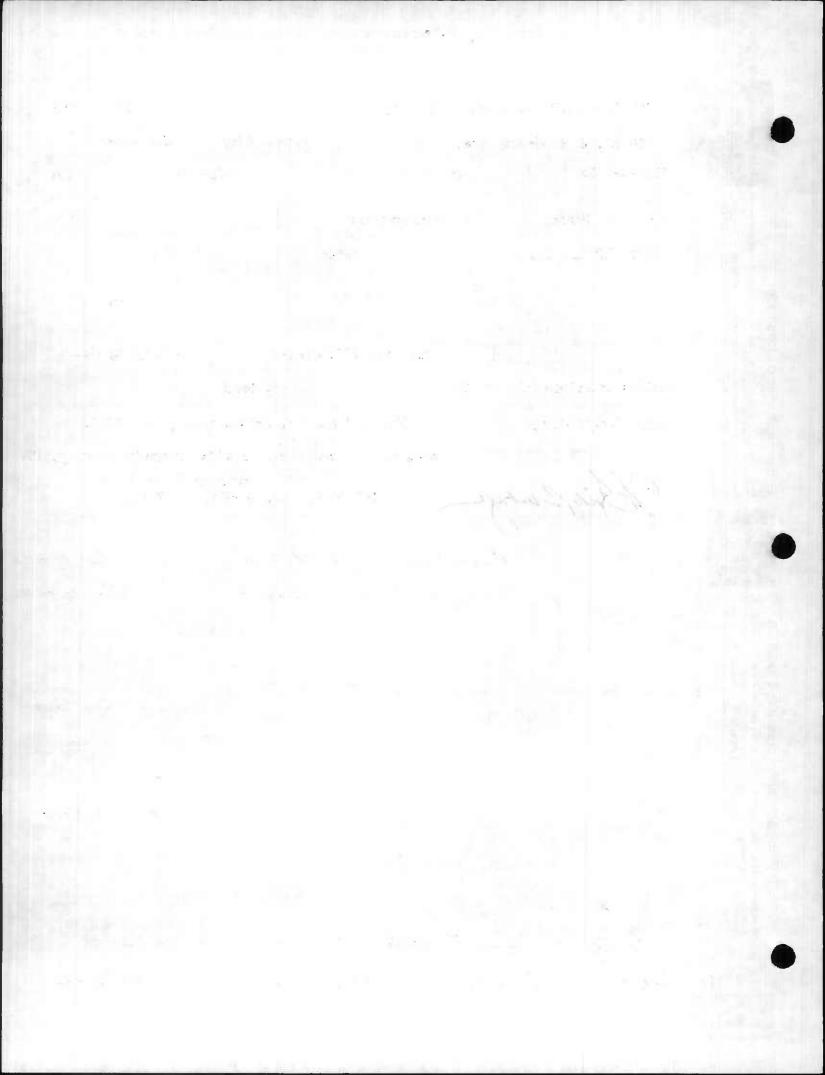


					Certificate of	Death		Reg. No.			
Physician /Medical		1. Decedent's Name (First, Middle, Last)  WILLIAM HARRISON HINTON, JR.						eth Day 4	98	3. Time of Death 0807	
Examiner	4a	Facility Name (If not institution, given 24th St. & Bal Social Security Number 6.5	timore Ave	(in yrs. last b	nirthday) If Under 1 Yeer	Ocean		Worce	ester	ce (State or Foreign	
Funeral Director	Usu	159-05-7958	X M 2□F 8	35	Yrs. Months Days	Hours M	fin. (Month, Da 7/30/	13	Country	PA	
or 28a-f show be notified at	10a	PA Bucks			wn or Location					I. Inside City Limits 1    Yes 2 No	
3a or 2	100	. Street end Number 1013 Hillside D	r.		10f. Zip Code 18966			USA	Whet Country	/?	
natural, or items 23a or 28a-f show dical Examinar must be notified at etect by Funeral Director	5	Manitel Status  1 Never Married 2 Married  3X Widowed 4 Divorced	12. Wes Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:		13. Wes Decedent of I	dispanic Orlgin? an, Mexican, Pu Specify:	(Specify Yes or No lerto Rican, etc.)	14. Rac Blac Specify	e - American ck, White, etc	с.	
		15. Decedent's Education (Specify only highest grade completed)			a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of I	in 16 ing most of working		16b. Kind of Business/Industry		
		Elementary/Secondary (0-12)	S	ecretary/Tre	easurer	Name (First Middle	Dredg		0.		
ked off	5	Father's Name (First, Middle, Last William Harrison					18. Mother's Name (First, Middle, I Mary Neal		, Maroen Surramer		
permit: ragas 1 and 2 should be Department of Health and Mental Important: if fram 27 is marked o any injury or other traumatic evenance.	-	a. Informant's Name/Relationship (			b. Mailing Address (Stree			er, City or Town,	State, Zip C	ode)	
		Elsie Boyd/ Dat	ughter		1013 Hillsid		outhampt		1896		
	20a.	. Method of Disposition  1 2 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	Removal from State	Ceorg	of Disposition (Name of lery, crematory or other pla ge Washingto	caPark n Mem.	9/8/98	Plymout		eting, PA	
	21. Signarde of Fineral Service Licensee  22. Name end Address of Fecility  Burbage Funeral Home  108 William St. Berlin, MD 21811									e	
the death certificate be executed y the ettending physicien and to the for use as the burial-transit and any stocian/Medical Examiner	dise	mediate Cause (Final ease or condition	Myss	14DX						Onset and Death	
physicial s the burnedical	Second Cau	quentially list conditions, ny, leading to immediate use. Enter Underlying use (Disease or injury t initiated events ulting in death) Last	b. Cozon	oue to (or as a large to (or as a	a consequence of):  ARTIERY a consequence of):  a consequence of):	DISE)			Sauce	N PUNCE	
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32. Registrar's Signature G. Sparks

State Registrar

31. Date filed (Month, Day, Year) SEP 0 9 1998



	State of Maryla				lealth and l		giene	2	8770	
1. Decedent's Name (First, Middla, Last)	eth		3. Tima of Death							
Mary Elizabeth	Kerns					August	31. 19	Yaar 998	2:40AM	
4a Fecility Name (If not institution, giva st			Time	- 1	b. City, Town, or	Location of Daath			2.10/11	
Manor Care					Chevy C	hase	Monto	aamer	v	
5. Social Sacurity Number 6. Sex		rs. lest birthday)	If Under	er 1 Year Days	If Under 24 Hrs Hours Min.	8. Dete of Birt	h		lace (Stete or Foreign	
577 <b>-</b> 48 <b>-</b> 5919	M 2XF 82	Yrs.	MONTHS	Days	Hours Miri.	Sept.	21,1915		ington DC	
Usuel Residence of Decedent	10-	Oh. Taus as La							and beside Object to the	
10a. Stete 10b. County	106.	City, Town or Lo	cation						1 ☐ Yes 2 XNo	
Maryland Prince Geo	orge's Ca	pitol H				-				
10e. Street and Number				ip Code			10g. Citizen of V		ntry?	
1105 Balboa				0743			U.S.			
	<ol><li>Wes Decedent Ever in Armed Forces?</li></ol>	U,S. 13.	Was Deci	edent of H ecity Cuba	ispanic Origin? (S In, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Rac	e - Amark k, White,	can indien, etc.	
1 ☐ Navar Marriad	1 ☐ Yes 2 No If Yes, Give		1 🗆 Yes	2 <b>XX</b> 00	Specify:		Specify	. Whi	ite	
	Year or Dates:	40a Dassi	dantia I la		atlan		16b. Kind of Bu	.oloooofin	duetos	
15. Decedent's Educi (Specify only highest grade		16e. Deced	kind of w	ork done i use retired	during most of wo f)	rking			ge's Co.	
Elementery/Secondary (0-12)	College (1-4or 5+)  V/A	Food			,		Board of	-		
5th Nama (First, Middla, Last)	N/A	rood	perv	ice	18. Mother's Na	me (First, Middle,			cacion	
John Crampt	con				Cora		field			
19a. Informant's Name/Relationship (Typ			_			urel Route Numbe				
Frank D. Kerns (Sor	·	1651			-	Road Acc				
20a. Method of Disposition  № Burial 2 □ Cremation 3 □ Re	moval from State	cemetery, crer	metory or	eme of other plea	Sept.	4,1998	20c. Location -	City or To	own, Steta	
4 ☐ Donation 5 ☐ Other (Specify)	Wa				al Cemet	wh.	Suitlan		-	
21. Signature of Funeral Service Licansee	Bil					ee Funer ia Ferry			MD 20735	
23a. Part1. Enter the diseese, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) a.	cause on each line.						rest,		Approximate Interval Between Onset and Death	
Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last	Due to	o (or as e consection of or as e consection or as e consection of or as e consection of or as e consection or as	quenca of	): Lery	Dise	Ase				
Part II. Other significant conditions conti	ributing to death but not readent I	esulting In the u		cause giv	en In Part I.	23b. Dld 1		ntributa t	o the cause of death?	
Peripheral Va	Ascular	Disea	se			24e. Wes	en autopsy med?	av cc	Vere eutopsy findings vailable prior to rmpletion of cause deeth?	
Hartonian						10,	res 2 No	1	□ Yes 2□ No	
25. Was case referred to medical			-		26. Place of De	eth (Check only o	ne)			
examiner?	spital: 1   Inpatient 2	☐ ER/Outpatier	nt 3 🗆 C	OOA Oth			tance 6 □Oth	ar (Speci	fv)	
27. Menner of Deeth  1 Natural 5 Pending 2 Accident Investigation	28a. Dete of Injury (Month, Dey Year)			28c. Injur Wor		28d. Dascribe		,,		
2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - Al building, etc. (Spe	t home, ferm, str cify)			165 2 10	28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)				
29a. Certifier (Check only one) 1 Certifying Physic 2 Medicat Examine	cian: To the best of my k er: On the basis of exami end manner stated.	nowledge, death	h occurre vestigetlo	d at tha tir	ne, dete and plece pinlon, deeth occ	e, and due to the urred at the time,	ceuse(s) and ma dete end place,	anner es a end due t	steted. o the cause(s)	
29b. Signature end title of cartifier		-	2	9c. Licens	e number		29d. Data signe	d (Month,	Dey, Year)	
Charle AL	promo	2		D3	0484		8/31	198		
30. Neme and eddress of person who com	npleted cause of deeth (I	tem 23e) (Type,	Print)							

State Registrar Charles Umosella
31. Date filed (Month, Dey, Year)
SEP 1 0 199

4333

1998

32. Registrar's Signature

Old

Branch

parks

Marlow Heights, MD 20748

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be datached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**Physician** /Medical **Examiner** 

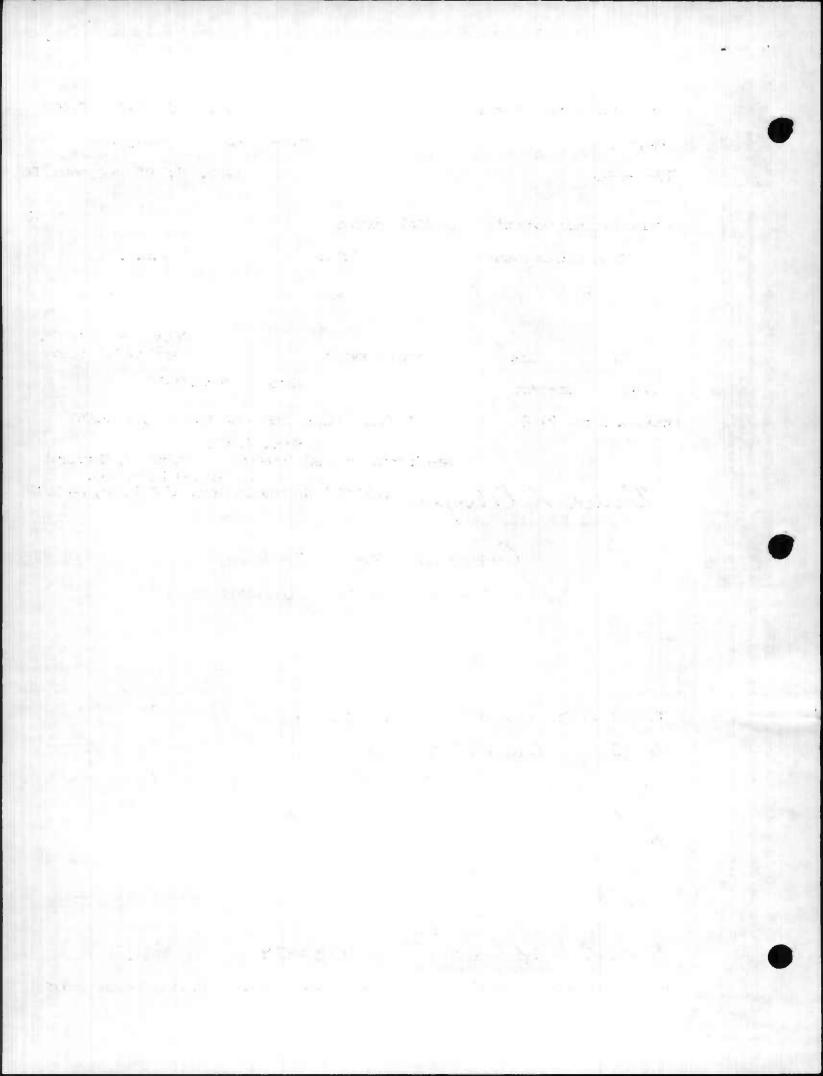
**Funeral** Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Department of Heelth and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinet must be notified at once.

Physician Alleuntai Examiner

Baltimore, Maryland 21215-0020

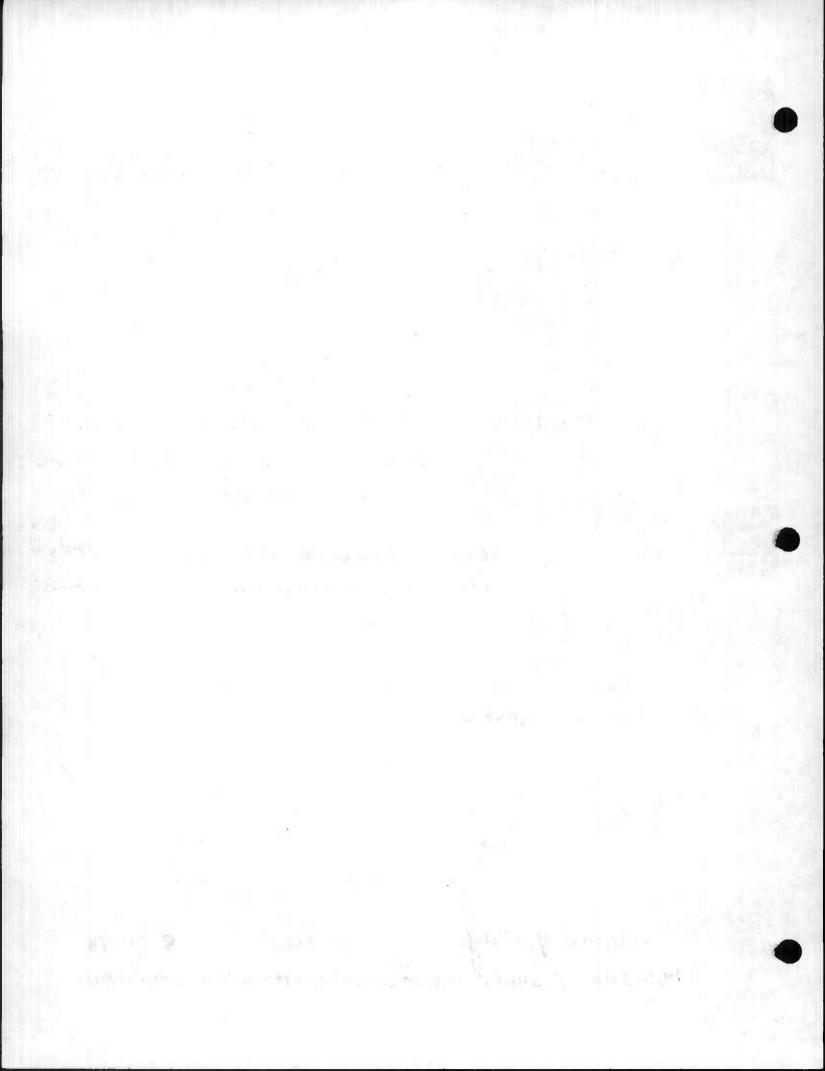
To Be Completed by Funeral Director



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Rea, No 1. Decedant's Nema (First, Middla, Last) 2. Deta of Daath 3. Tima of Death **Physician** Month CHARLES CALVIN KLINE 08 1998 7:15 P.M. /Medical 4e. Facility Nama (If not Institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COLTON VILLA NURSING CENTER HAGERSTOWN WASHINGTON | H Undar 1 Year | H Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) | 9. Birthplaca (State or Fore Country) | MARCH 23, 1911 | PENNSYLVANIA 5. Social Sacurity Number 7. Age (In yrs. last birthday) **Funeral**  Birthplaca (State or Foreign Country) 1X M 2□ F 219-20-1576 Yrs. Director 87 Usual Rasidance of Dacedent with the Meryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Merylan Depertment of Heelih and Mental Hygiaen.
Important: If tiem 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic avent, the Medical Examiner man be notified at 10a. Stata 10b. County 10c. City, Town or Location 10d. inslda City Limits Director 1 Yas 2 No MARYLAND WASHINGTON BOONSBORO 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 7720 SHARPSBURG PIKE 21713 U.S.A. Funeral 12. Was Decadant Ever in U,S. Armad Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) Race - American Indian, Black, Whita, atc. 1 Never Marriad 20 Marriad 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Dates: Maryland 21215-0020 1 ☐ Yes 2 No Spacify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) 6 YEARS FARMER FARMING 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Be WILLIAM KLINE SUSAN NAILE 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) RUTH ANN KAETZEL, DAUGHTER 19313 BETTY AVENUE, BOONSBORO, MARYLAND Baltimore, 21713 20a. Mathod of Disposition 20b. Piaca of Disposition (Nama of cematary, cramatory or other piece) 20c. Location - City or Town, Stata Data Buriai 2 Cremation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) BEAVER CREEK CEMETERY 09/01/1998 HAGERSTOWN, MARYLAND 21. Signatura of Funaral Sarvice Licensee 87 Or 22. Nama and Addrass of Facility 7606 OLD NATIONAL PIKE BAST FUNERAL HOME 0 BOONSBORO, MARYLAND STEVEN DANFELT, JR. 21713 23a. Part1. Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immadiata Causa (Final disaasa or condition rasulting in daath) CEREBROVASCULAR ACCIDENT. 1 MONTH Examiner Due to (or as a consaquance of): Examiner ROSTRATE CARCINOMA sician end buriel-transit Sequantially list conditions, if any, laading to immediata ceusa. Entar Undarlying Causa (Disaasa or injury that initiated avants Due to (or as a consequance of): the attending physician hed for use as the burie Box 68760 Nowe certificate be Physician/Medical Due to (or es e consaquence of): rasulting in daath) Lasf X NONE Part fl. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contributs to the cause of death? signed by 1 Yss 2 No 3 Probably 4 Unknown me þ 8 24a. Was an autopsy parformad? 24b. Wara autopsy findings available prior to completion of ceusa of death? Completed peed hes page 2 1 Yas A No certificate 1 ☐ Yas 2 No 25. Was cesa rafarred to medicei axaminar? Be 28. Placa of Death (Chack only ona) Hospital: 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) To 1 ☐ Inpatiant 2 ☐ ER/Outpetienf 3 ☐ DOA this ...spital or Attending Pi in 24 hours after death. uneral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 1 Natural
2 Accidant 2 | No 5 Panding Investigation Director: A WA MAM 1 🗌 Yas WIL 28f. Location (Straat and Number or Rurel Route Number, City or Town, Stata) 6 Could not be datarmined 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 3 Sulcida 4 ☐ Homicida NIA 1 Certifying Phyaician: To tha best of my knowledga, daath occurred at tha tima, data and place, end dua to tha causa(s) and mannar as statad.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the ceusa(s) and mannar stated. 29a. Cartifian Medical (Check only one) within 2 To the I the 29d. Data signed (Month, Day, Year) 29b. Signature end titla of certifier 29c. Licanse number 0 D28365 2.28.98 Nama and addrass of person who completed ceusa of death (Itam 23a) (Type, Print) 9ANZAR. J. SHAPI 368 MILL STREET HAGE 18700 NMD 21740 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State AUG 3 1 1998 Sparks Registrar

**DHMH 16 Rev 6/95** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27, 1998 Month Reginald Lamont King 3:20 AM August 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fredrick Md. F
If Under 24 Hrs. 8. Date of Birth
(Month, Dey, Year) Fredrick Fredrick Memorial Hospital If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 10 M 20 F Months Days 217 82 7847 4/2/63 Md. Usual Rasidence of Decedent 10c. City. Town or Location 10b. County 10d. Inside City Limits Washington Was 2 No Hagerstown 10f. Zip Code 10g. Citlzan of What Country? 109-18 Bayberry Court 21740 USA 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Race - American Indian. Black Whita etc. Never Married 2 Married 1 ☐ Yes 2 X No 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Dry WallHanger

18. Mother's Name (First, Middle, Maiden Surnema) Laborer 17. Father's Name (First, Middle, Last) Agnes King Broadus

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Code) James Phillip Wallace 19a, Informant's Name/Relationship (Type, Print) Agnes King Broadus (mother) 109-18 Bayberry Ct. Hagerstown, Md. 2

20a. Method of Disposition

20b. Place of Disposition (Nama of cemelery, cremetory or other placa)

20c. Location - City or Town, Stata Md. 21740 17 Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify) Rest Haven Cemetery 8/31/98 Hagerstown 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Watson Funeral Home 24 W. Bethel St. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death Aspiration Puenmenia Due to (or es e consequence of) Henangiopericytoma
Due to (or as a consequence of): Due to (or as a consequence of):

**Physician** /Medical Examiner

physician and s the burial-tran

use as

signed by t

certificata

director,

funeral

or Attending Physician: after death. Director: After this certific

To the Hospital or within 24 hours aft To the Funeral Di complataly filled in

Records, P.O. Box 68760

Division of Vital

Examiner

Physician/Medical

P

Completed

Be

2

Certification:

Medical

**Physician** 

/Medical

Examiner

Director

Funeral

by

Completed

Be

10a. State

Md.

10e. Street and Number

**Funeral** 

Director

7 is marked other than "natural", or flems 23s or 28s-f show traumatic event, the Medical Examinar must be notified at

with the Maryland

altimore. Maryland 21215-0020

Pages 1 and 2 should be filed within tent of Health and Mental Hygiene. nt: if them 27 Is marked other than

other

0 Department of Important: if any Injury or pace.

Immediate Ceuse (Final

disaasa or condition resulting in death)

24a. Was an autopsy performed?

28d. Describe how injury occurred

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in daalh) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SRIZUre Disordes

23b. Did tobacco use contribute to the cause of death? 1 Yes 275 No 3 Probably 4 Unknown

24b. Were eutopsy findings available prior to completion of cause of death? 1 Tyes 2 □ No

25. Was cese referred to medical exeminer? 1 Yes 2 No

Nonpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

1 ☐ Yes 2 No 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death Natural 2 Accident 5 Pending investigation 6 Could not be determined 3 Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MO

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Streat and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)

4 | Homicide

TECCTITYING Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier

29c. Licensa number

29d. Date signed (Month, Dey, Year)

Tolino

MO 051610

Frederick MD

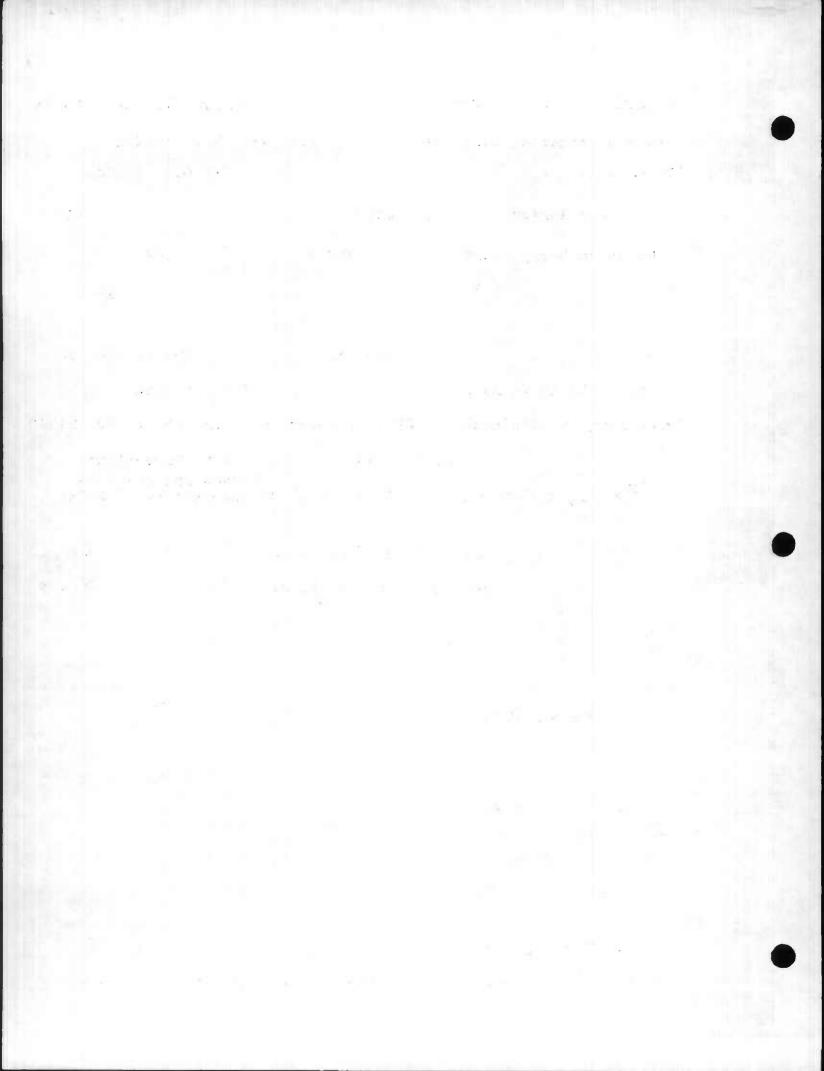
8-27-98

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

AUR laney 31. Date filed (Month, Dey, Year) AUG 3 1 1998

200 Suite 32. Registrar's Signeture

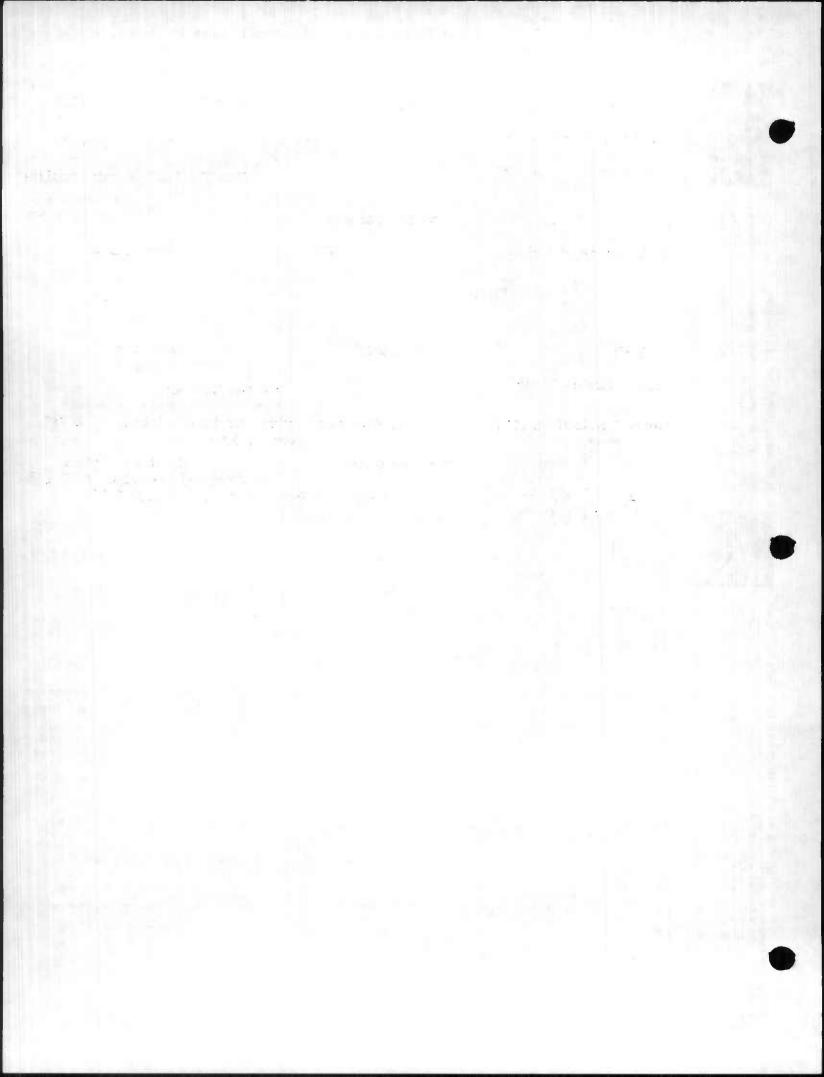
State Registrar



State of Maryland / Department of Health and Mental Hygiene

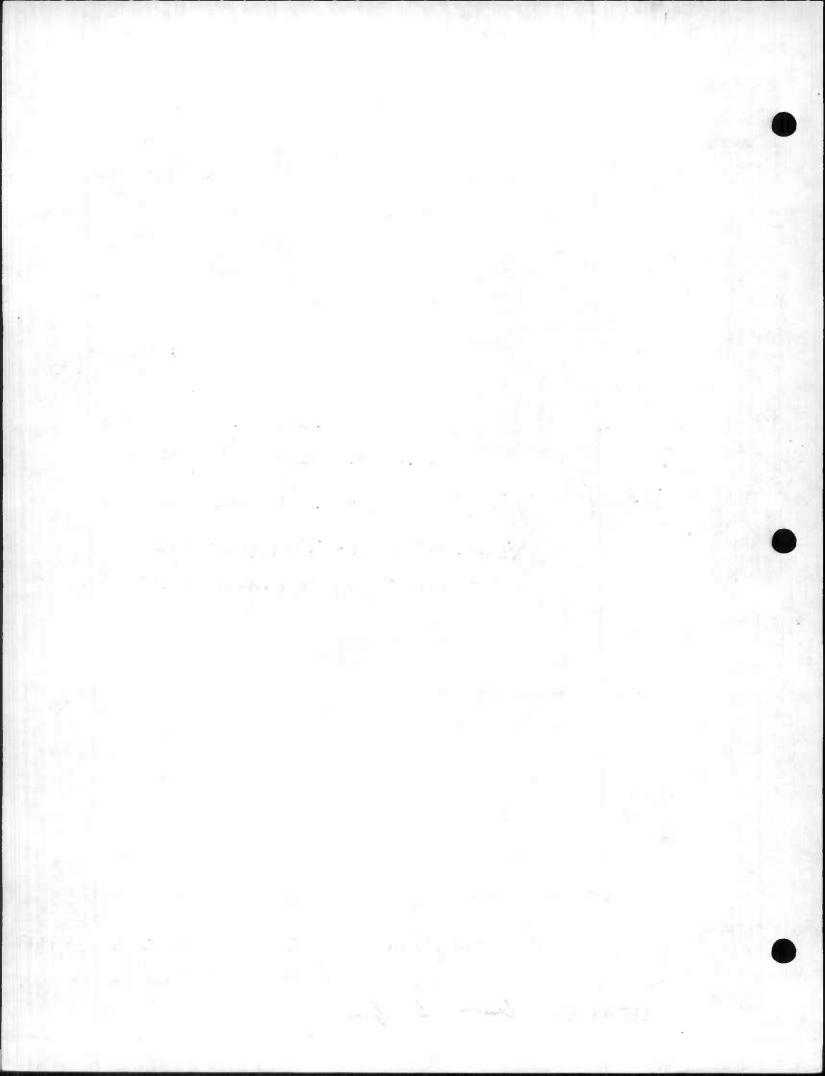
Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middla, Last) Sept 6, 1998 **Physician** 0115 Outine Lillian Langley /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, giva streat and number) Examiner Southern Maryland Hospital Prince George's Clinton

If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (Stata or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 1 M XXF 69 579 34 5965 Yrs. **Director** Feb 27, 1929 North Carolina Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Med cal Examena, must be notified as 1 ☐ Yes 2XXNo Director Capitol Heights P.G. 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 20743 United States 2017 Grovewood Drive permit. Pagas 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28 any Injury or other traumatic event, the Medical Experimentation. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes \$45 No If Yes, Give V Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. Bleck, White, etc. 1 Never Married 2 Married 1□ Yes No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Elamentary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 18. Mothar's Name (First, Middla, Maidan Sumama) 17. Father's Name (First, Middla, Last) Edward Vivian James Ora Lee Hatchell 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 2017 Grovewood Drive, Capitol Heights, Md 20743 Harry Langley (HUSBAND) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Placa of Disposition (Nama of cematary, cramatory or other place) Sept 8, 1998 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland Lee Crematory 21. Signature of Funeral Service Licanses 22. Name and Address of Facility Eee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md 20735 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disaasa or condition rasulting in daath) ours Examiner Due to (or as a consequence of): Examiner Myscarchal rouss physician and tha buriel-transit Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Causa (Disaase or injury that initialed avants resulting in daath) Last Due to (or as a consequence of) Lows Division of Vital Records, P.O. Box 68760 The law requires that the death certificete be Physician/Medical Due to (or as e consequenca of): 80 Electolyte attending DisTurbance 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. bean signed by the should be dateched 1 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? certificata has page 2 2 300 1 ☐ Yas 2 ☐ No 1 Yas or Attending Physician: 25. Was case referred to medical axaminar? Be 26. Place of Death (Check only ona) To 1 Yes 2 No Hospital: 1 Nnpatient 2 □ ER/Outpatient 3 □ DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) this funaral 27. Manper of Death 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 5 Pending Investigation 1 Yes 2 No deeth. 2 Accident within 24 hours efter deeth To the Funeral Director: / completely filled in by the 6 Could not be datarmined 3 Suicide 28e. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida Hospitai 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical pletely (Check only one) 29b. Signatura end title of certifiar 29c. License number 29d. Date signed (Month, Day, Year) 0 09 06 D26352 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) O. Haye 20735 Clanton lis cataway 31. Data filed (Month, Day, Yaar) 32. Registrar's Signature SEP 10 1998 Registrar

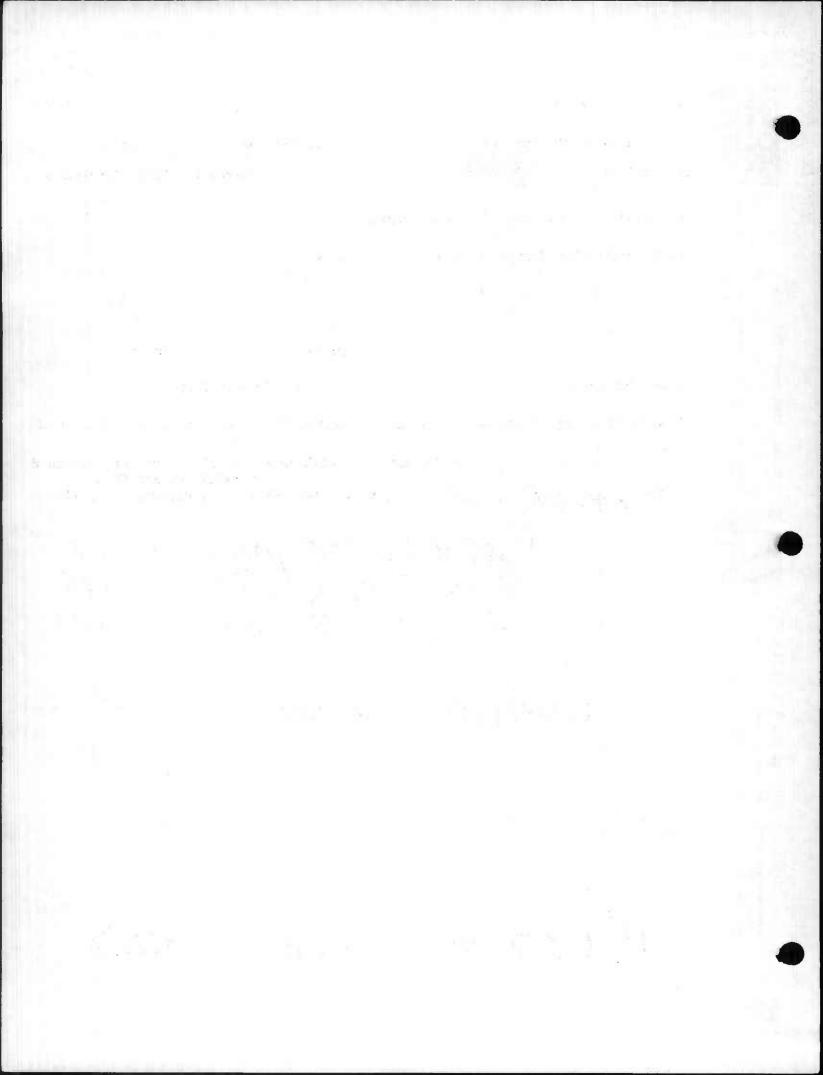


State of Maryland / Department of Health and Mental Hygiene

_	Certificate of	Death Reg. No. 98 28774
Physician	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Dey Yeer 3. Time of Death
/Medical	IVAN MARTIN LAYTON	August 28 1998 0840
Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
	PENINSULA REGIONAL MEDICAL CENTER  5 Social Security Number 6 Sex 7 Ane (In vrs. last hirthday) If Under 1 Year	SALISBURY WICOMICO  T M Under 24 Hrs.   8 Date of Birth   9 Birtholece (State or Foreign
uneral irector	579-28-4808 1⊠ M 2□ F 72 Yrs. Months Days	
288-7 show	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
ber met be notified at uneral Director	Maryland Wicomico Salisbury	1 ☐ Yes 2 ☑ No
I Direc	10e. Street and Number 10f. Zip Code 802 Little John Drive 218	10g. Citizen of What Country? USA
by		Hispanic Origin? (Specify Yes or No- ban, Mexican, Puerto Rican, etc.)  14. Race - American Indien, Black, White, etc.
Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	during most of working
0	12 - Engineer	Telephone Co.
B	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
2	Paul Layton	Hattie Jones
other treumatic event, trail.  To Be Comp		at and Number or Rural Route Number, City or Town, State, Zip Code)
Je .	Mary E. Layton/Wife 802 Little 20a. Method of Disposition (Name of	John Dr., Salisbury, MD 21804
and injury or outer treum	1 ⊠ Burial 2 □ Cremetion 3 □ Removel from State 4 □ Donation 5 □ Other (Specify)  Maryland Veterans	aca)
ian ical ner	23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dy shock, or heart feiture. List only one cause on each line.  Immediate Cause (Final disease or condition	Intervel Between Onset end Deeth
In/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
Physician/M	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause gi	iven in Pert I. 23b. Did tobacco use contribute to the cause of death?
d by Physician/N		1 Yes 2 No 3 Probably 4 Unknown
hour per		24a. Wes an autopsy performed?  24b. Were eutopsy findings aveilable prior to completion of cause of death?
0		1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No
o Be Compl	25. Was case referred to medical examiner?	26. Placa of Deeth (Check only one)
ĕ -	1 Yes 2 No Hospital: 1 Conpatient 2 ER/Outpatient 3 DOA Of 27. Manner of Death 1 Matural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Wo	ther: 4 Nursing Home 5 Residence 6 Other (Specify)  uny at ork?  Yes 2 No
Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)
completely filled in by the funeral	29a. Certifier (Check only one)  1 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	
Completely filled in by the funer Medical Certification	29b, Signature and title of certifier 29c. Licen	nse number 29d. Date signed (Month, Dey, Year)
10	TOM, MARTIN	X 2075   AUGUST 28,1998
State	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ENTER POLICY  31. Date filed (Month, Day, Year)  SEP 0 1 1998  Aparts  Aparts	A REGIONAL MEDICAL CENTER



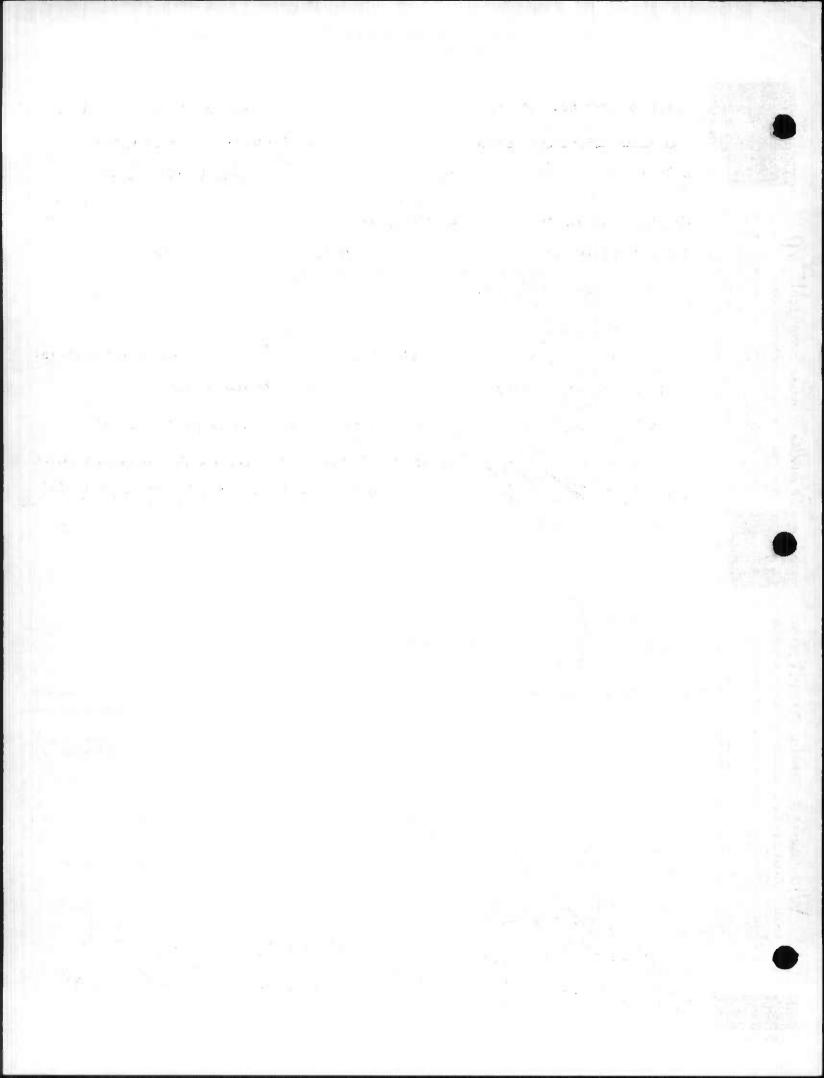
Physici. /Medic		Decedent's Nama (First, Middle, L	ast)		Cen	tificate of	Death	2. Date of De	Reg. No.	3. Time of Death
		Anna Mae LINDBER	RG					AWGUST	- 2b.	1998 11:24 AI
Examin		4a. Fecility Nama (If not institution, g	ive street and number)	)			4b. City, Town, or Lo	1100		of Deeth
uneral irector		Washington Count 5. Social Sacurity Number 171–20–7602 6.	Sex 7. Ag	ga (In yrs. las	st birthdey) Yrs.	If Undar 1 Yaar Months Days	Hagerston Munder 24 Hrs. Hours Min.	8. Date of Birl (Month, Da	Wa th y, Year) 15, 192	ashington  9. Birthplaca (Stete or Foreig Country)  Pennsylvani
2		Usuel Residence of Decedent  10a. Stata 10b. County		10a City	Town or Loc	atlan				
28a-f show	5		ington		gersto					10d. Inside City Limits PD Yes 2 DNo
28a-f	Funeral Director	10e. Street and Number	1116011	11dg	serseo	10f. Zip Coda			10g. Citizen of V	
23a or	ō	44 E. Washington	Street. A	nt. 1		217	7.4.0		USA	
2 2	era	11, Maritel Status	12. Was Decedent Armed Forces?	-	13. W			ecity Yes or No		e - Amaricen Indian,
ral', or items Examiner m	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Yas, specity Cuba □ Yes 2 ☑ No	dispento Origin? (Sp an, Maxican, Puerto Specify:	Ricen, etc.)	Blac	ck, White, atc.
natural',	ted	15. Decedent's 8 (Specify only highest g	Education		16e. Decede	ent's Usual Occup	pation during most of work d)	Ina	16b. Kind of B	usinass/industry
The Man	Completed	Elamentary/Secondary (0-12)	College (1-4or	5+)	lifa. D	housewi		nig	her h	nome
sout,	Be	17. Fathar's Name (First, Middla, Las	st)				18. Mother's Name	a (First, Middle,	Melden Surnan	ne)
erka etic	2	Moses Habecker					Bertha	Mae Gi	ube	
E E		19a. Informant's Neme/Relationship Amos M. Lindberg					and Number or Run			State, Zip Code)  wn, Md. 21740
Important: If item 27 is merkad othe any injury or other traumetic event, once.		4 Donation 5 Other (Spec 21. Signatura of Funeral Sarvice Lice 23a. Part1. Enter tha disease, or cor	Minu	ed	22.	Name and Addre	ilson Blv	MINNICH d., Hag	FUNERAL erstown	, Md. 21740
sician edical miner		23a. Part1. Enter tha disease, or conshock, or haart failure. List only Immediate Cause (Final disease or condition rasulting in death)	y one cause on each li	PS 15	- (1	PRUBAG	LE GRA	m M	SAM	Approximate Interval Between Onsat and Death
d ansit	Examiner	Sequentially list conditions	Bes	SPIR	s a consequ	My 1	MILLIK	25-		1425-
attending physician end for use as tha burial-transit	edicai	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Lest	c. LE	Due to (or as	1/ev	201	EHVSU	w		Wks.
igned by the attendin be detached for use	Physician/M	Part II. Other significant conditions	contributing to death b	ut not resultin	ng in the und	derlyInd ceusa giv	ren in Part I.		obacco use con	ntribute to the cause of deat
ped b	by	U N	IN HOUSE	1016		VIRW	/CW.	24e. Was	an eutopsy	24b. Were eutopsy findings
shoul	Completed								med?	evailable prior to completion of causa of daeth?
has 38.2	CO	OF Man ones referred to medical						101		1 ☐ Yes 2 ☐ No
ate has	00	25. Was cesa raferred to medical examinar?  1 Yes 2 No	Hospital:	0055	2/0	2□ DOA Oth	er: Deatl			
ate has	0	27. Manner of Death	28a. Date of Inju		NOutpatient  Bb. Time of Injury	28c. Injur	4 Li Nursing Ho		lence 6 LIOth now Injury occur	
ftar this certificate has inaral director, paga 2	ation: To	1 Naturel 5 ☐ Pending 2 ☐ Accident Investigation	211					28f. Location (S	Street and Numb	and Direct Day to March and
ftar this certificate has unaral director, paga 2			be on Place of the	ury - At home c. (Spacify)	a, rarm, stree	et, factory, office		City or Tou	m, Stata)	er or Hural Houle Number,
ftar this certificate has inaral director, paga 2	edical Certification:	2 Accident 3 Sulcida 4 Homicida  29a. Certifier    Investigation   Investigation	28e. Place of Injuding, etc	of my knowle	dga, daath d	occurred et tha tin	na, data and place,	City or Tow	ceuse(s) end ma	
he Funeral Director: Aftar this certificate has pletaly filled in by the funaral director, paga 2	Certification:	2 Accident 3 Sulcide 4 Homicida  29a. Certifier (Check only)  Medical Example:	28e. Place of Injuding, etc.  hysicien: To the best of Injuding.	of my knowle	dga, daath d	occurred et tha tin	na, data and place, pinion, death occurr	City or Tow and dua to tha ded et tha tima, d	ceuse(s) end madata and place,	nner es stated.



State of Maryland / Department of Health and Mental Hygiene

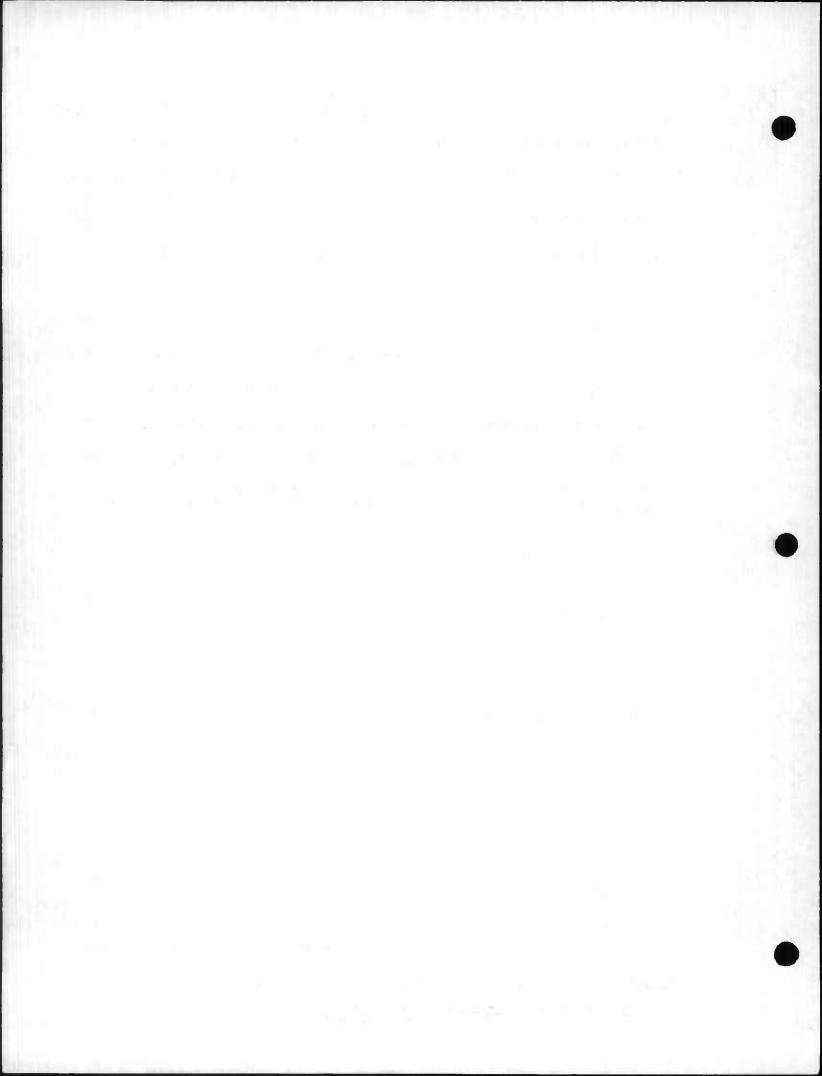
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** William Lawrence Lonsway 26,1998 11:20 P.M August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Washington Homewood Retirement Center Williamsport 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 6. Sex 1 M № 2 □ F Birthpiece (State or Foreign Country) **Funeral** 292-03-5788 Yrs. Director 96 Dec. 8,1901 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ris 23a or 28a-f show must be notified at 1 Yes 2 No Director Maryland Washington Williamsport 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Ave. 21795 USA Items 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. event, the Medical Examiner 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Merried 2 X Married 'natural', or 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuei Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use ratired) Flementery/Secondary (0-12) Collaga (1-4or 5+) 12 Chemical/Industrial Sales Rep. 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mantal Anna Bertha Lucius William Leonard Lonsway Important: If item 27 is m any injury or other traum once. 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 16505 Virginia Ave. Williamsport, MD 21795 Verna M. Lonsway/Wife 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetien 5 ☐ Other (Specify) Smithsburg Crematory Aug. 27, 1998 Smithsburg, Maryland 21. Signature of Funerei Service Licer 22. Name and Address of Fecility 425 S.Conococheague St. Williamsport, MD 21795 Osborne Funeral Home Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardlec or respiratory errest, or hear milure. List only one cause on aech line. **Physician** /Medical Immediata Cause (Fine disease or condition resulting in death) Examine Due to (or es a consequence of) attending physician and for use as the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequance of) P.O. Bok 68760. Physician/Medical Due to (or es a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? of Vital 25. Was case referred to medical axaminar? Be 26. Place of Deeth (Check only one) Othar: 45 Nursing Home 5 ☐ Residenca 8 ☐ Other (Specify) 1□ Yes 2No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28c. Injury et Work? 27. Manner of Death 28e. Deta of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Aftar 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No death. 2 Accidant Director: / 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) or A after 4 Homicide hours a Funeral Medical To the Hosp within 24 hou To the Funer completely fil 29e. Certifler Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) end menner as steted. eminer: On the besis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end mennar steled. 29b. Signature and 1946 of a 29c. License number 29d. Dete signed (Month, Day, Year) no completed cause of daeth (Item 23a) (Type, Print) 31. Dete filed (Month, Dey 32. Registrar's Signature State AUG 28 Registrar

**DHMH 16 Rav 6/95** 



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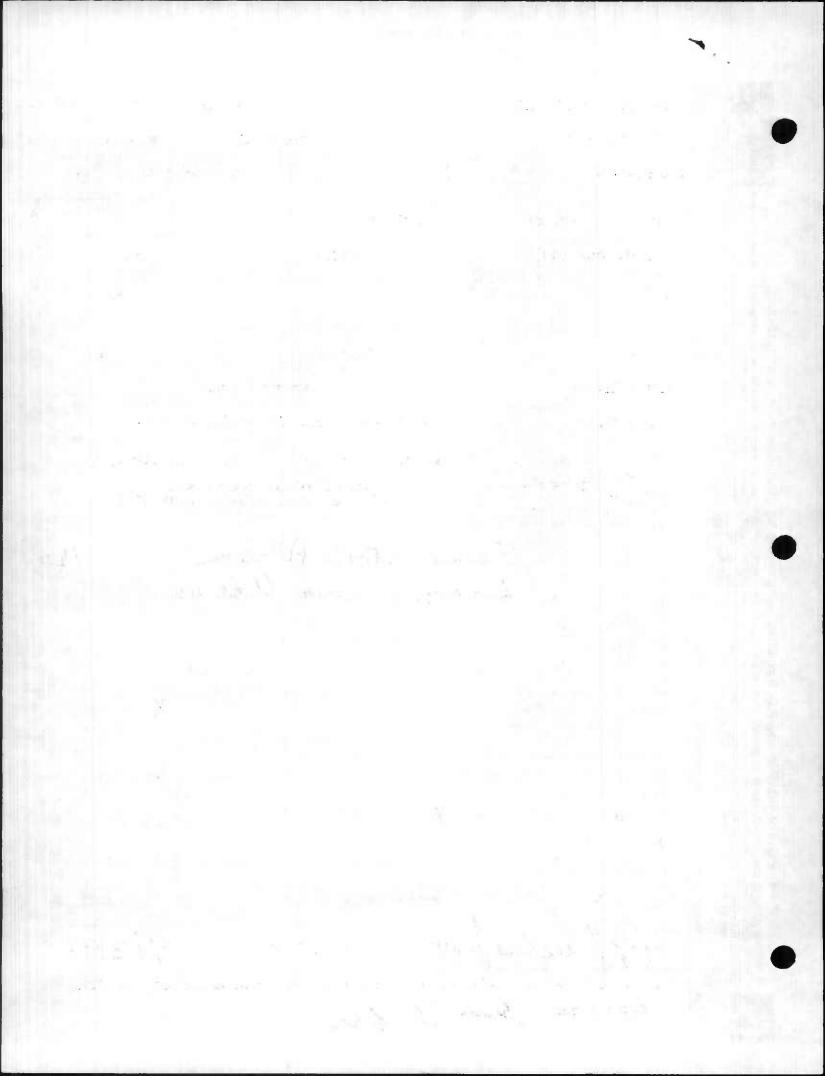


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Bernice Deloris Mills 8:55 P.M August 26 1998 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6211 Perdue Road Pittsville Wicomico If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
April 28,1938 5. Social Sacurity Number Birthplaca (Stata or Foraign Country) 7. Aga (In vrs. last birthday) **Funeral** 1□ M 2 1 F Months Days 60 SC 250-56-2429 Director Usual Rasidenca of Decedant deeth with the Meryland 10c. City, Town or Location r 28a-f show 10a State 10h Count 10d. Insida City Limits 1 Yas 2 No Director MD Wicomico Fruitland 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? "naturel", or items 23s or P. O. Box 811 21826 U.S. Funerai 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer c Depertment of Health and Mental Hygiene. Important: if itam 27 is marked other than "naturel", or item any injury or other traumatic event, tra Medical Evanties. Black, Whita, etc. 1 Navar Married 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: P 3 Widowad 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Dacedent's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 7th Collaga (1-4or 5+) Housewife n/a 18 Mother's Name (First Middle Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Otis Williams Rosenna Hunter 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, State, Zip Code) Nathan Mills 6211 Perdue Rd., Pittsville, MD 21850 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Surial 2 Cremation 3 Ramoval from Stata 9/1/98 Green Acres Mem Park Salisbury, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility
Lewis N. Watson Funeral Home 21. Signature of Funeral Service Co. 1618 West Rd., Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of) Examiner omy o sarc physicien end the buriel-transit thet the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avents rasulting in daath) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai Dua to (or as a consequanca of): 98 ettending for use es 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the signed by the 3 Probably 4 Unknown p The law requires 24b. Wara autopsy findings available prior to completion of cause of death? been si 24e. Wes en autopsy performed? Completed director, page 2 s 2 0 No 1 Vas 1 ☐ Yas 2 ☐ No al or Attending Physician: T s efter deeth. I Director: After this certificet od in by the funeral director, p 25. Was case referred to medical axaminar? Be 26. Placa of Death (Chack only one) 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidanca 8 Othar (Specify) P 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Mennar of Death Certification: 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? 1 Natural 2 Accidant 5 Panding 1 ☐ Yes 2 ☐ No invastigation 6 Could not be datarmined 3 Suicida 281. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homicida To the Hospital or within 24 hours eft To the Funeral Di completely filled in 1th Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and dua to the cause(s) and mannar es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and plece, end due to the cause(s) and mannar stated. 29a. Cartifier Medical 29b. Signature 29c. Licansa number 29d. Data signed (Month, Day, Year) 30 Name nd address of person who complated causa of death (Itam 23e) (Type, Print) Dr. Clifford Wheeless, 2411 W. Belvedere AVe., Ste. 406, Baltimore, MD 21215 32. Ragistrar's Signatura 31. Data filed (Month, Day, Year) SEP 0 4 1998 State

Locals

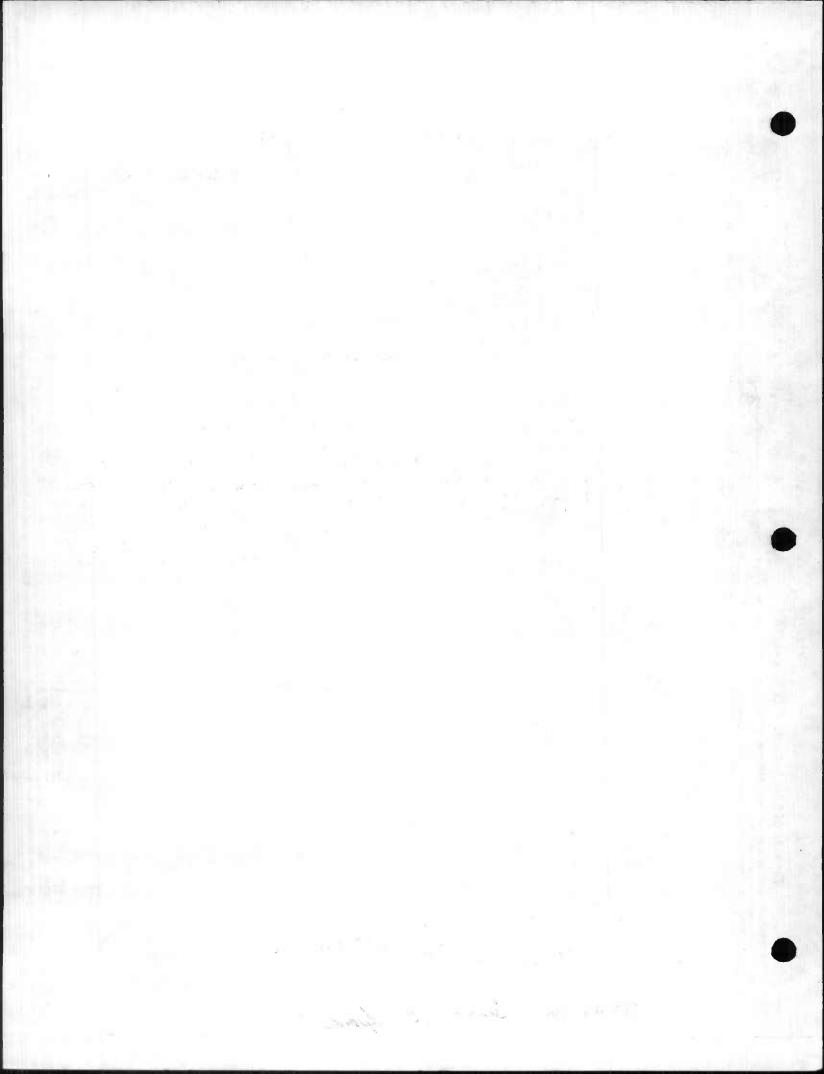
**DHMH 16 Rev 6/95** 



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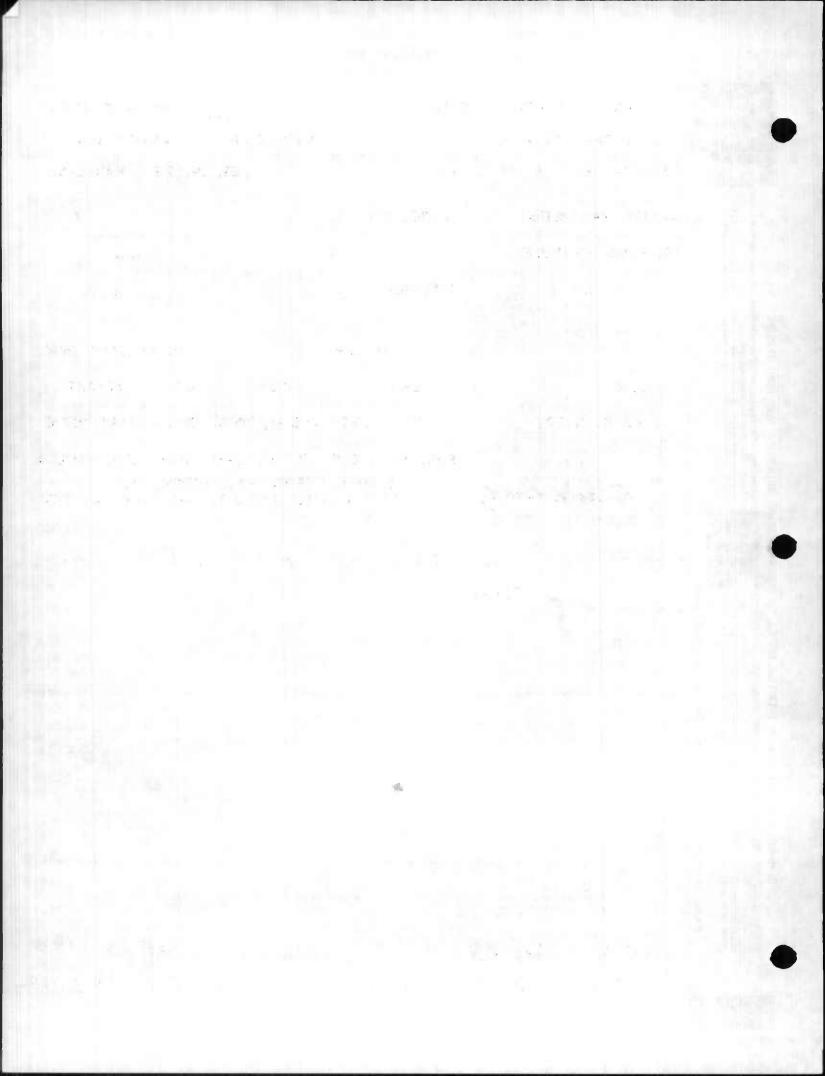
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Physician	1. Decedent's Name (	(First, Middle, La	st)					2. Dete of Dea Month	Day	Year 3. Tima of D
/Medical	Robert		ranklin		M	iller		Deptem	1	1998 09
Examiner	4a Facility Neme (If n						4b. City, Town, or L		4c. County	
	PENINSULA					f Under 1 Year	SALISI		WICOMI	
uneral irector	5. Social Security Num 234–24–443	32	M 2 F	7. Age (In yrs. las		fonths Deys		8. Date of Birth (Month, Day February		9. Birthplaca (State or F Country) West Virgin
1	Usuel Residence of De 10a. Stete 1	Ob. County		10c. City,	Town or Locat	ion				10d. Inside City
28e-f sho notified at rector	MD	Wicom	ico		Salis					1 ☐ Yes 🎇
be notified Director	10e. Street end Numb					10f. Zip Code			10g. Citizen of V	Vhat Country?
0 20										
iner mat Funeral	1020 S. SC	chumaker	12. Was Deca	dent Ever in U,S.	13. Wa	s Decedent of	21804 Hispanic Origin? (Si	pecify Yes or No-	14. Rac	USA e - American Indian,
Fun	1 ☐ Never Merried	2 Married	Armed For	ces? Marine			Hispanic Origin? (Sp ban, Mexican, Puerto	Rican, etc.)	Blac	k, White, atc.
à	3 □ Widowed 4 [		If Yes, Giv Yeer or Do	e wwii	10	Yes 2 No	Specify:		Specify	White
te bet		5. Decedent's Ed			16a. Deceden	t's Usual Occu	pation	la la a	16b. Kind of Bu	siness/Industry
Completed	Elementary/Second	only highest greater (0-12)	College (1	-4or 5+)	life. DO	NOT use retin	during most of worked)	king	A T &	T and
TOC.	12	, , ,	2		Retire	Distr	ict Super	visor	C&PI	elephone Co
Be	17. Fether's Name (Fin	irst, Middle, Last,					18. Mother's Nan	e (First, Middle,	Maiden Sumam	(e)
To	Martin	William	Mil.	ler Sr.			Alice	Virginia	a Brant	ner
- In	19a. Intormant's Nam	ne/Relationship (	Type, Print)	100	19b. Mailing	Address (Stree	et and Number or Ru	rai Routa Numbe	r, City or Town,	State, Zip Code)
*	Dorothy A.	Miller	/ Spouse	2	1020 S	Schum	aker Dr.	Salisbu	ry, MD	21804
6	20a. Method of Dispos	sition	-	20b. Pled	ce of Dispositi	on (Name of ory or other pl	la.	Dete		City or Town, State
ary or	4 Donetion 5	Other (Specif	y)	Sali	sbury (	Cremato	ry	9/7/97	Salisbu	ry, Marylan
N III	21. Signature of Fune	eral Service Licer	pee /	Mojos	22. N	ame end Addr	ess of Fecility		c	-1 2
E & 8	D /	i ak	1/2		п	-				al Associat
	23a. Part 1. Enter the shock, or haert to	diseese, or com	plications thet co	d the deeth.	Do not enter t	he mode of dy	Hill Roa ring, such es cardiac	or raspiratory ar	rest,	Approximata
sician	snock, or naert to	tellura. List only	one causa on e	7/1	11	1	1 11	1		Onset end De
edical	Immediate Cause (Fir disease or condition	nel		Muni	111170	11 1	THH	mila	LOLA	to al
niner	rasulting in death)		A	Due to (br a	is a conseque	nce of):			ywa	will
i i			N. C.	V		ENGEN.			V	
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EX EX	Sequentially list condi if any, leading to imme cause. Enter Underly	ediate ring								İ
s the bu	Cause (Disease or Injuthat initiated events resulting in deeth) Las		c	Due to (or e	s a consequer	nce of):				
N 100	maana maan									
etached for use Physician/			9				1000			
ysic	Part II. Other algnifica	ant conditions c	ontributing to de	ath but not resulti	ing In the unde	ertying cause g	iven in Part I.	23b. Dtd t	obacco use co	ntribute to the cause of
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à å										I an was a second
should leted								24a. Was	en eutopsy med?	24b. Were autopsy tine available prior to completion of cau
rector, page 2 s										completion of cau of death?
Completed								10Y	es 25040	1 Yes 2 N
B et	25. Was case reterred examinar?	d to medical	Mana Nati			1-	26. Place of Dea	th (Check only o	ne)	
9 5	1 Yas 2 No	D				3LI DOA		ome 5 Resid		
	-			t Injury h, Day Year)	8b. Time of Injury	28c. Inju		28d. Describe h	now injury occur	red
eu o	-	5 Pending				M 10	Yes 2□No			
the funer cation:	-	investigetion 6 □ Could not b	0			4		OOL Lacettee 11	Manual and other of	na na Guest Courte At
by the fune tification	-	investigation  6 Could not be datarmined	e 28e. Plece	ot fnjury - At hom- ng, etc. (Specify)	e, ferm, street	, fectory, office		28f. Location (S City or Tox	Street and Numb m, Stete)	er or Rural Route Numbe
by the fune tification	27. Mannar ot Death 1 Natural 2 Accident 3 Suicide 4 Hornicide	investigetion 6 Could not be datarmined	28e. Plece buildin	ng, etc. (Specify)				City or Tox	m, Stete)	
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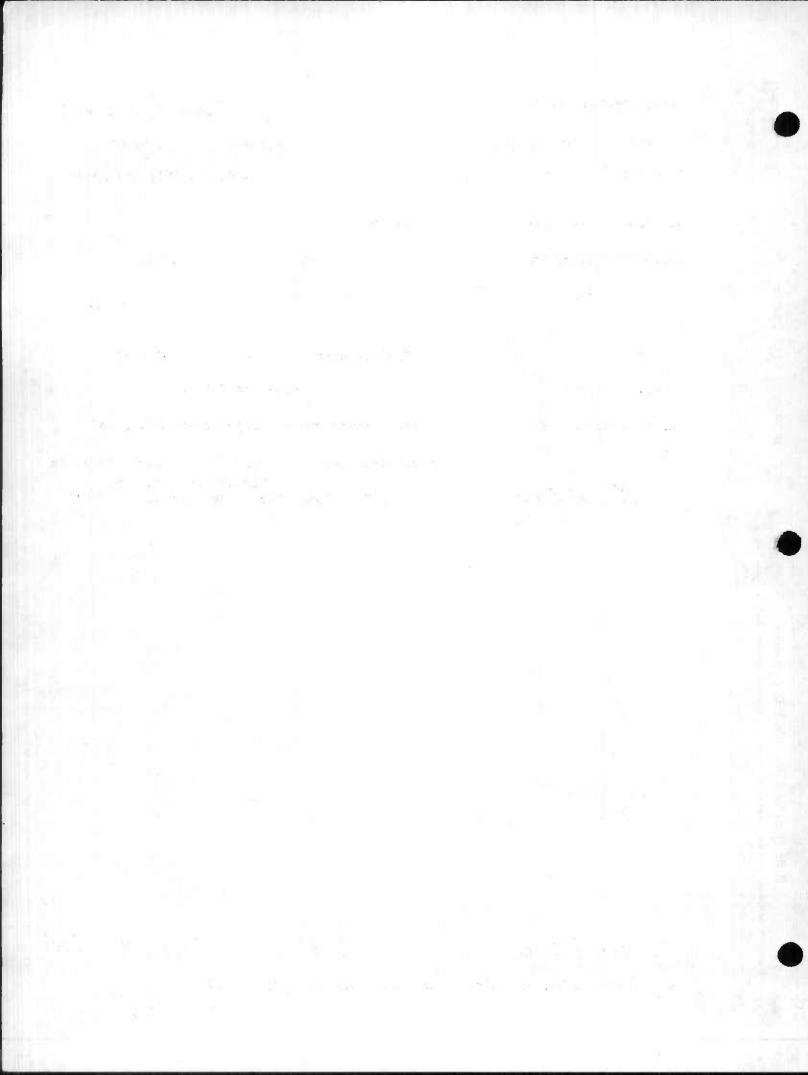
							Cei	rtificat	e of	Death			Reg. N	lo.			
		_	1. Decedent's Name (First, Middle	, Last	)		F-577			1,000		2. Deta of De Month		011	Year	3. Time	of Death
	Physician /Medical		ELMER	LEP	OY	MYE	RS					5-cb	-	ay 8	1998	1:13	- PM
7	Examiner		4a Facility Nama (If not institution	-		er)	N. T.					ocation of Deal		c. County	of Death		
			434 STRATFO	RD	AVENUE					HAGE				WASH	IINGT	ON	
	Funeral Director		5. Social Security Number 214-09-3084	6. Se	7	Age (in yrs	s. last birthdey) Yrs.	If Unde Months			Min.	8. Data of Bi	th av. Yea 9, 19	19	9. Birthp Coun MAF	iace (Sta try) YLA	te o <i>r Foreign</i> ND
	and w	- 1-	Usual Rasidence of Decedent  10a. State 10b. County			10c. C	City, Town or Lo	cation	_		-				1	Od. Inside	City Limits
	vith the Maryl or 28a-f sho be nout ed	200	MARYLAND WASHIN	GTC	)N	Н	AGERSTO		Onde				40- 0	***************************************	What Coun		′es 2□No
	ath with a 23a or 2	3	10e. Street and Number 434 STRATFORD A	VEN						740				U.S	.A.		
21215-0020	72 hours efter death with the Maryland netural; or items 23a or 28s-f show dies Examine frust be notified at shed by Funeral Director	2	11. Marital Status  1 □ Navar Married 2 ☑ Marr  3 □ Widowed 4 □ Divorced	ed	12. Was Decede Armed Forca 1 X Yas 2[ If Yes, Give Yaar or Data	s? □ № 19	41–1964	Was Dece If Yas, spe 1 1 Yas	dent of cify Cu 2 No	ban, Maxice  Specify		pecify Yas or N o Rican, etc.)	0-	Bla	ce - Americ ck, Whita, y: WHI	atc.	le
5-0	"natural",		15. Decedent				16a. Dece	kind of wo	ork don	e durina mo	st of worl	king	16b.	Kind of B	usiness/ind	dustry	
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Maryland	Sais S		LEROY	-431/			MYERS			MAG	GGIE		MAE		WEY	ANT	
-	20 2 2		19a. Informant's Name/Relations WILMA J. MY						,			rel Route Numl HAGERST					740
Baltimore	permit. Peges 1 end Depertment of Heelth Important: If Item 27 any Injury or other tr once.	1	20a. Method of Disposition  1X Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S)		temoval from Sta	te	Place of Dispo cemetery, cres DSE HI	metory or	other pi		09-	Date -11-98			OWN,		
Balti	permit. Peges Depertment of Important: If It any Injury or once.		21. Signature of Funeral Service		Brady	-						UNERAL REET, I				מו	1740
		+	23a. Part1. Enter tha diseasa, or		ications that caus	ed the dea								HOIU	WIN, I	Approxi	
68760,	deeth certificate be executed  e ettending physician and of for use as the burial-transit  sician/Medical Examiner		disease or condition resulting In death)  Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated avents		Bra	Due to	(or as e consec	quence of)	:	- Jr		70 70	5	<u>c</u>		yme	1145
Box 687	n certificete be anding physicia use es the bur In/Medical		resulting In deeth) Lest	L,	1	Due to	or as a conseq	quence of):									
			Part II. Other significant condition	ns cor	ntributing to death	bul not re	sulting In tha u	nderlying	cause g	given In Part	i.	23b. Dic	Itobaco	co uae co	entribute to	the cau	ee of death
P.O.	signed by the ettending be detached by the ettending be detached for use by Drystclan/N											1	Yee	2□ No	3 Pro	bably	0 Unknow
Records,	been shou											24a. Wa	s an aut	opsy	av	ere autop allable pr mpletion death?	
Ĭ	The law ete hes page 2											1 🗆	Yes	2 DiNo	10	Yes :	2 No
120	certificate rector, pag		25. Was cese referred to medicel examiner?				***			26. Plac	e of Dea	th (Check only	one)	1			
or Vital	Physician: this certific ral director,		1)⊠ Yes 2 No	ŀ	lospital: 1 ☐ Inpa	atient 2[	☐ ER/Outpatier		UA		iursing H	ome 50 Res	idence	6 □Oth	ner (Specif	(y)	
o uois	To the Hospital or Attanding Physician: Within 24 hours effer deeth.  To the Funeral Director: After this certific completely filled in by the funeral director.  Medical Certification: To Be (		27. Manner of Death  1 Naturel 5 Pendin  2 Accident Investig	ation	28a. Dete of It (Month, I	njury De <i>y Year)</i>	28b. Time o Injury	M	28c. Inj W 1 [	ury at ork? Yes 2	] No	28d. Describe					
Division	s efter day in Direct		3 Suicide 6 Could a determ	ined	28e. Place of building,	Injury - At etc. (Spec	home, farm, sti cify)	reet, factor	y, office	0		28f. Location City or To			ber or Rure	al Route I	Vumber,
	To the Hospital or Attanding in within 24 hours effer deeth. To the Funeral Director: After completely filled in by the funeral Director. Medical Certification				sician: To the be- ner: On the basis end manner	of axemin											se(s)
	within To the comp		29b. Signatura and titla of certified		1			29	c. Lica	nsa numbar			29d. C	Data signa	ad (Month,	Dey, Yes	ır)
			· Alu.	Wa	al ke	el_				0112	64	6	S	ept	8	17	98
			30. Name and address of person	Ve	empleted ceuse of	Mideath (Ite	580 580	Nov	The	un A	· ;	Hager	5/	ow	4 1	12	21742
	State Registrar		31. Date filed (Month, Day, Year) SEP 1	19	98 32. Regi	strar's Sign	natura	. 14	par	Ks							



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician					Cei	uncate	of Dea	ath		Reg. No		
Physician	_	. Decedent's Neme (First, Middle	e, Last)						2. Dete of De	ath		3. Time of Deeth
/Medicai		Marvin Richard	MUNCH						Month	Da	y Year 5, 1998	6:00PM
Examiner		e. Fecility Name (If not institution	, give street and number	er)			4b. Ci	ty, Town, or L	ocation of Death		County of Death	O.OUFH_
	ı	RAVENWOOD LUTH	ERAN VII.I.A	GE			1	HAGERST	OWN	1	WASHINGTO	ON
Funerai	5	. Sccial Security Number	6. Sex · 7.		last birthdey)	If Under 1	Yeer if L	Inder 24 Hrs.	8. Date of Birt	th		piace (Stete or Forei
Director	-	553-16-9362 Usual Residence of Decedent	1 M 2 □ F	81_	Yrs.	Months D	Days Ho	ours Min.	(Month, Da April ]	9 1	917 Vir	ginia
28a-f show	1	0e. Stete 10b. County		10c. Cit	y, Town or Lo	cation					1	IOd. Inside City Limi
oto oto	3	Maryland Washi	Ington	]1	Hagerst	town						1 ☐ Yea 2 ∏ N
r items 23a or 28a-1s	1	0e. Street end Number				10f. Zip Co	ode			10g. Cit	izen of Whet Cour	ntry?
23a	ŝ	11210 Greenberr	v Road				2174	0		U.	S.A.	
ltams Det.m	1	1. Marital Status	12. Was Deceder Armed Force	nt Ever in U,	S. 13. V	Vas Deceden	t of Hispen	ic Origin? (Sp	ecify Yes or No- Rican, etc.)		14. Raca - Americ Black, White,	
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natural',	3	15. Decedent		-	16a Deced	lent's Lleuel C	Iccupation			16b K	ind of Business/In	
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merked other than matic event, the Mar		Elementary/Secondary (0-12)	College (1-40	or 5+)							A *	
Hydra Hydro		7. Fether's Name (First, Middle, I			100	ol Plan		Mother's Nam	e (First, Middle,		Aircraft	
if Health and Mental Hygines 27 is merked other other traumetic event,	í										· ·	
I Meni		Cyril H. Munch			1				Mae Rite			
1 2 2 2		19e. Informent's Name/Relationsh	nip (Type, Print)		19b. Mailin	g Address (S	itreet end N	lumber or Rui	al Route Numbe	er, City o	r Town, State, Zip	Code)
Health em 27 other tr	-	Lucy C. Munch	- Wife					y Rd. I		own,	Md. 217	40
f ite	2	0a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3   Removel from Stat		lace of Disposemetery, crem	sition (Name ne <i>tory or oth</i> e	of er plece)		Date	20c. Lo	ocation - City or To	own, State
nent of I		4 Donation 5 Dother (Sp			norama	Cemete	ery	9	/10/98	Vate	rlich, V	irginia
Department of Health Important: If Item 27 any Injury or other tr once.	1	21. Signeture of Funerei Service t	icensee		22	. Name and A	Address of I	Table.			ral Home	
Depe impo any li		1 7.11	151		/. 1	15 E T	Ji 1 000	n Blvd.			wn, Md.	
	+-	23a. Part1. Enter the diseese, or shock, or heart failure. List	complications that cause	ed the deet							wii, Mu.	Approximate
hysician /Medical xaminer	, r	mmediate Ceuse (Finel disease or condition esulting In deeth)	ө		r as e conseq						20	Jears
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MUNCH, Marvin Richard

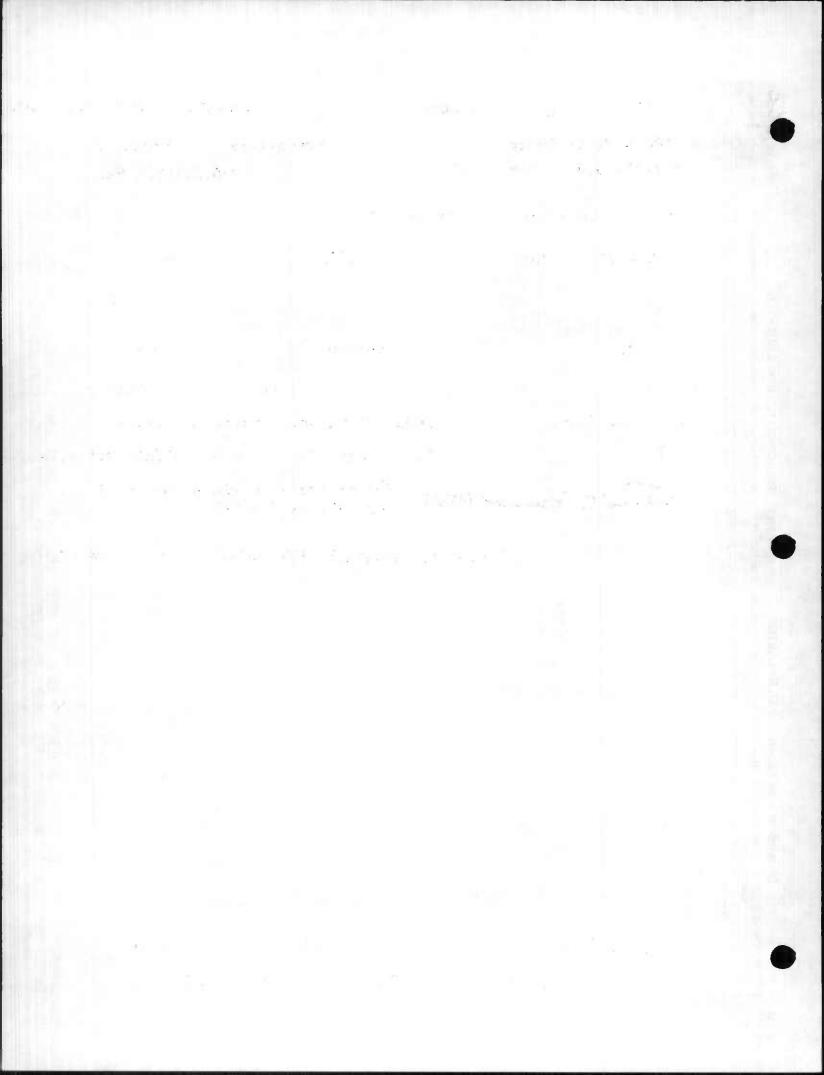


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) Month Day **Physician** 1998 September 4, Gladys Manges 4:00 P.M. NMN /Medicai 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Myersyille
If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10054 Vista Court Frederick

9. Birthplace (State or Foraign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2√F 172-30-4908 87 Yrs. Feb. 2, 1911 Director Pa. Usual Rasidence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiena. Important: If Item 27 is marked other than "netural", or items 23a or 28a-f show any Injury or other traumatic avent, it a Medical Examiner must be notified. 10a State 10c City Town or Location 10d Inside City Limits 10b County Md. Frederick 1 ☐ Yes 2 No Myersville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21773 10054 Vista Court USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give " Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black White, etc. 1 □ Navar Married 2 □ Married 1□ Yes 24 No Baltimore, Maryland 21215-0020 Specify: SpecifiWhite p 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) College (1-4or 5+) Elemantary/Secondary (0-12) Homemaker Home 18. Mother's Name (First, Middla, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hugh Wertz Sarah Beaner 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10054 Vista Ct.Myersville,Md.21773 Ruth Hoyt/Dau. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/8/98 Buffalo Mills, Pa Milligans Cove Cem 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funarai Service Licensee 22. Name and Address of Facility Burner Trade Services 1037 Dual Pl. 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** Immediate Cause (Final disease or condition rasulting in death) /Medicai 2 MONTH HEAR Examiner Due to (or as a consaquance of) Examiner physician end s the burial-transit law requires that the death certificete be axecuted Sequantially list conditions, if any, leading to Immediate cause. Entar Undarlying Cause (Disease or Injury that Initiated events resulting in daath) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): ettending ph I for use es ti signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 □ Probably 4 Unknown by 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed certificate has b 1 Yes A No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ona) Othar: 4 Nursing Home 5 CRasidance 8 Other (Specity) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending invastigation 1 Watural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) in by 4 Homicide filled 24 hours 1 Certifying Phyaician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and titla of certifier 9-4-99 mo 30. Name and addrass of person who completed cause of death (Itam 23a) (Type, Print) # 204 SOFIS CIM FMFORVICIC 31. Date filed (Month, Day, Year) SEP 08 32. Registrar's Signature State Registrar



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State of Maryland /	Department	of Health and	Mental Hygiene

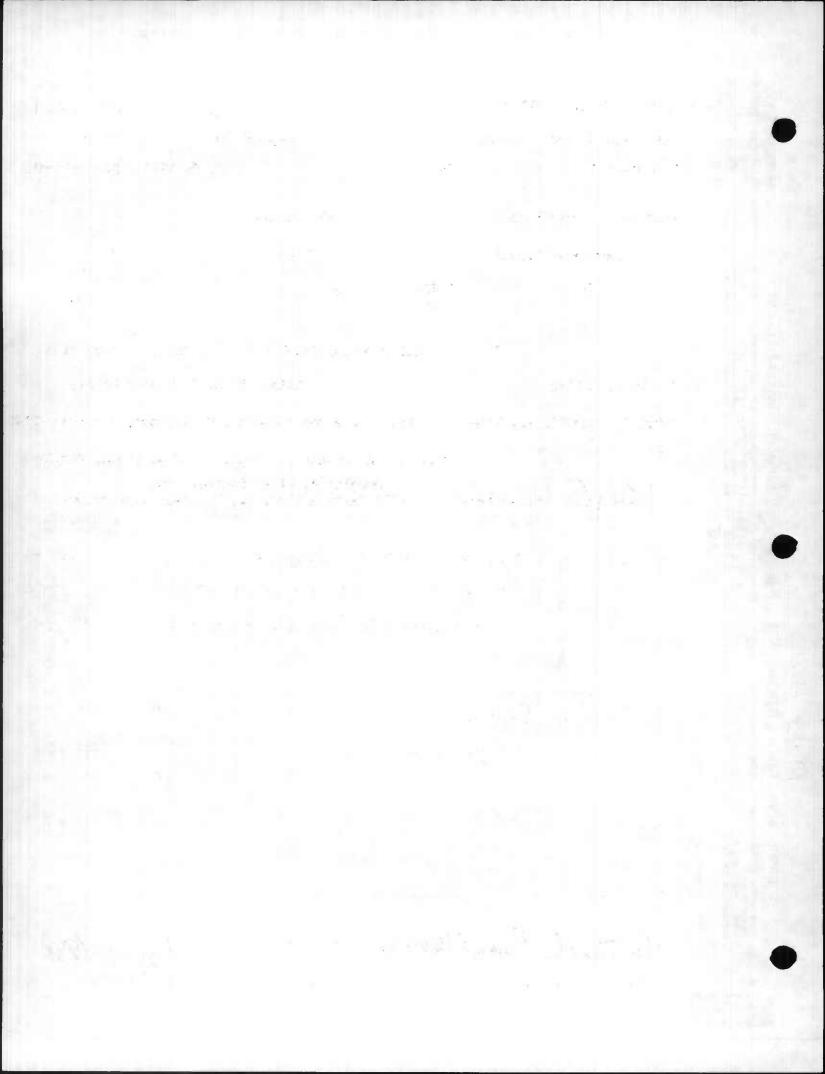
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Physician /Medical Examiner	Immediate Car disease or con resulting In dea	use (Finel	7.	o.  Dua to (or es e	in 1	Increas					Intervel Between Onset end Deeth
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The level ate has page 2								10	Yes 2 No	1[	□Yas 2□ No
f Vital Re in yelden: The is cartificate hadirector, page		referred to medical					26. Plece of	Deeth (Check only	one)	1	
of Vita Physician: this cartific ral director,	exeminer?	2 No	Hospital:	nt 2 ER/O	utnatient 3	DOA	thor	g Home 5 DRe		ner (Specif	v)
ding Phys. h. After this tuneral d		Death 5 Pending	28a. Dete of Injur (Month, De)	y 28b.	Time of Injury	28c. Inj W			how Injury occur		,,
Division Complete in by the tuners completely filled in by the tuners.	2 Accide 3 Sulcid	e 6 ☐ Could no	t be Geo Place of Inju	rry - At home, fe . (Specify)	erm, street, f	ectory, office	9		(Street end Numi own, Stete)	ber or Run	ai Route Number,
Hospita     1.24 hours     Funerel     letely fille	29e. Certiflar (Check onl		Phyetcfan: To tha best of taminer: On tha besis of and menner ste	exeminetion er							
To the To the comp		and titla of certifier	tyle mo			07	nsa number 26579		29d. Dete signe 9/2/98	ed (Month,	Day, Year)
		addrass of person wh	no complated cause of de	eeth (Item 23a) Hagus	(Type, Print)	nd.	R.	L. Kugler	-, mo.		
State Registrar		SEP 0		r's Signature	19.	Spo	rks	L. Kugler			

ANTIC medical and associate for the sub-

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

					Certificate of	f Death	Reg	ı. No.	20104
		1. Decedent's Name (First, Middle, L	ast)			P. P.Y.	2. Date of Death	Day Year	3. Tima of Death
	Physician /Medical	Harry Gochenour	Miller				August	30 1998	1301
	Examiner	4a Facility Name (If not institution, gi				4b. City, Town, or L		4c. County of Death	
		Washington Count	y Hospital			Hagers			ngton
	Funeral Director	5. Social Security Number 196–10–6852	Sex 1 M 2 F 7. Age	75 (In yrs. last bir	thday) If Under 1 Ye Yrs. Months Day		8. Date of Birth (Month, Day, )	9. Birth	nplace (State or Foreign ennsylvania
100	P .	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n ar Loontian				10d. fnside City Limits
	with the Marylar or or 28s-1 show		hington	Toc. City, Yow		Hagerstown			1 ☐ Yes 2X No
	2 - 4		Avenue		10f. Zip Code	21740	100	g. Citizen of What Cou USA	
0020	or, or her	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify C	of Hispenic Origin? (Spuban, Mexicen, Puerto No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Amer Black, White Specify:	
Maryland 21215-0020	ed within 72 ho ygiane. or than "natur. t, the Modical Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College_(1-4or 5		Decedent's Usual Oc (Give kind of work do life. DO NOT use ref	ne during most of work	king	6b. Kind of Business/li Count	У
27	d withing giane.	12	6	Pul	olic School	l Teacher	В	oard of Ed	lucation
pu	be file tal Hy d other	17. Father's Name (First, Middle, Las					ne (First, Middle, Ma		
Ya	Ment Ment Price To	Harold E. Miller				Elizabe	eth M. Go	chenour Mi	ller
lar	2 sh and le m	19a. Informant's Name/Reletionship			. Mailing Address (Str				
	f Heelth Hem 27 other tr	Patricia Ann Mi	ller, Wife						aryland 21740
Baltimore,	Pages nent of int: If It iry or o	20a. Method of Disposition  1   Burial 2 □ Cremation 3    4 □ Donetion 5 □ Other (Spec			Disposition (Name of ry, cremetory or other) Haven Ceme			oc. Location - City or 1 Hagerstown	n, Maryland
Balt	Dependit. Depending	21. Signeture of Funeral Service Lice	l drunks	)		dress of Facility S A. Fiery			1
		23a. Part1. Enter the dheuse, or co shock, or head to ure. List on	politations that ceused year cause on each lin	the death. Do		ern Blvd. I			ryland 21742 Approximate Interval Between Onset and Death
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)	a. Hypo	xic	Brain	Damage			2 weeks
	executed in and iel-transit		. Acut	Due to (or as a	consequence of):	Infan	ction		2 weeks
68760,	ifficata be g physicia as the bur	Cause (Disease or Injury that initiated events resulting in death) Last	· Arter	ioscle	consequence of):	oronary 1	Artery	Disease	15 years
lar Box	attending for use a		d						
H.	the att	Part II. Other significant conditions	contributing to death bu	ut not resulting la	n the underlying cause	given In Part I.	23b. Dfd tob	acco uae contribute	to the cause of death?
, P.O.	ed by detac	Severe	Asthn	na			1 □ Yes	2 2 Pro 3 □ Pr	robably 4 🗀 Unknown
Mille Records	aw requires so been so 2 should		15 ye	ears c	Imation		24a. Was an performe	ed?	Were autopsy findings available prior to completion of cause of death?
<u>a</u>		25. Was cese referred to medical				OS Dines of Deep	1 Yes		1 ☐ Yes 2 ☐ No
5	Physician: The I this cartificate he ral director, pege	examiner?	Hospitai:	nt 2□ER/Ou	stpetient 3 DOA	Other	th (Check only one	ce 6 Other (Spec	oifu)
ō	Phy rale	27. Manner of Death	28e. Dete of Injur (Month, Day			njury at Nork?	28d. Describe how		ny)
ion	ath.	1 ☑ Naturai 5 ☐ Pending 2 ☐ Accident investigation		(Year) I		Yes 2 No			
Division of Vital	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not determined		ury - At home, fa c. (Specify)	ırm, street, factory, offi	се	28f. Location (Stre City or Town,	eet and Number or Ru State)	rel Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled		hysicfan: To the best o miner: On the basis of end manner sta	examinetion an					
	To the within To the comp	29b. Signature and title of certifier	Persone	l Phys	Cian D	ense number 08359	290	d. Dete signed (Month	1, Day, Year)
		30. Neme and eddress of person who	completed cause of de	eath (Item 23a)	2.1	Aug	Hag. M	127	741
	State	31. Date filed (Month, Day, Year)	22. Registra	ar's Signature	otomac	111	may. It	U	

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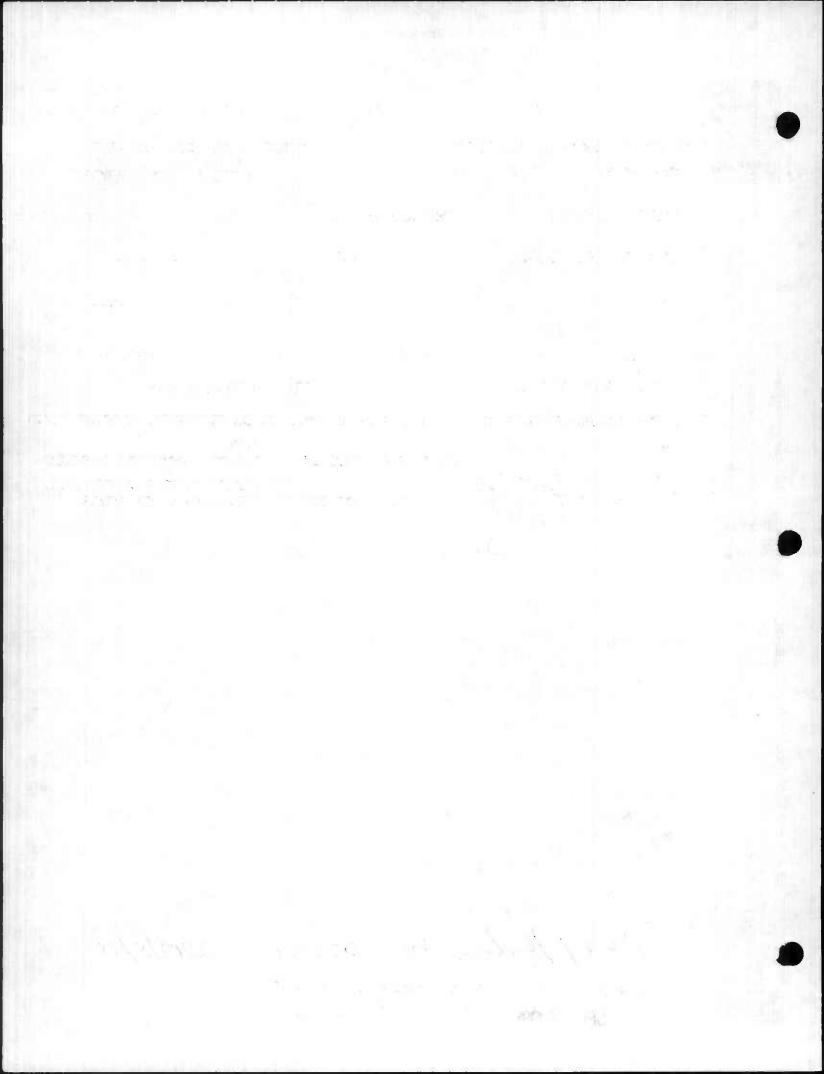


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** EDNA JUNE MONICA 0454 AM SEPTEMBER 5, 1998 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner CALVERT MEMORIAL HOSPITAL PRINCE
If Under 1 Year | If Under 24 Hrs. FREDERICK CALVERT 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (Stete or Foreign Country) Funeral 1□ M 2□xF Months Deys Yrs. 578-10-9954 Director 78 APRIL 15,1920 MARYLAND Usual Residence of Decedent the Marylend 10a. Stete show 10b County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Director MARYLAND CALVERT PRINCE FREDERICK 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 110 WESTLAKE BOULEVARD 20736 U. S. A. Funeral deeth 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☐ XNo If Yes, Give Yeer or Dates: 13. Was Decedent of Hispenic Orlgln? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. filed within 72 hours efter 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 XNo Specify: by Specity: 3 XWidowed 4 ☐ Divorced WHITE Completed Decedent's Usuel Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) The Medical 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 10 BILLING TELEPHONE COMPANY 7 is marked other traumatic event, Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Pages 1 end 2 should be in nent of Heelth end Mentel ADOLF WAGER TRIESLER MILDRED PAULINE SITES 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Heelth e : If itsm 27 is r or other tra 425 PAULA TERRACE PRINCE FREDERICK, MARYLAND 20678 SHARON COLLINS / DAUGHTER 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete SEPT. 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Department of Important: If any injury or FT. LINCOLN CEMETERY BRENTWOOD, MARYLAND 8,1998 21. Signature of 22. Neme end Address of Fecility LEE FUNERAL HOME CALVERT, P.A. 8125 SOUTHERN MD BLVD. OWINGS, MD for the disease, or complications that eaused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, heart failure. List only one ceuse on each line. Approximete Intervel Between Onset and Deeth **Physician** myocardial in face por /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-trensit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760, physician Due to (or es e consequence of): use es Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, ģ 90 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed director, page 2 should 24a. Wes en eutopsy performed? Deen this certificate 2 - No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Wes case referred to medical examiner? Be 28. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo 1 ☐ Yes 2 No s efter dea. 27. Menner of Death Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigetion 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide ò To the Hospital o within 24 hours of To the Funeral Di Medical 29e. Certifier 12xCertifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

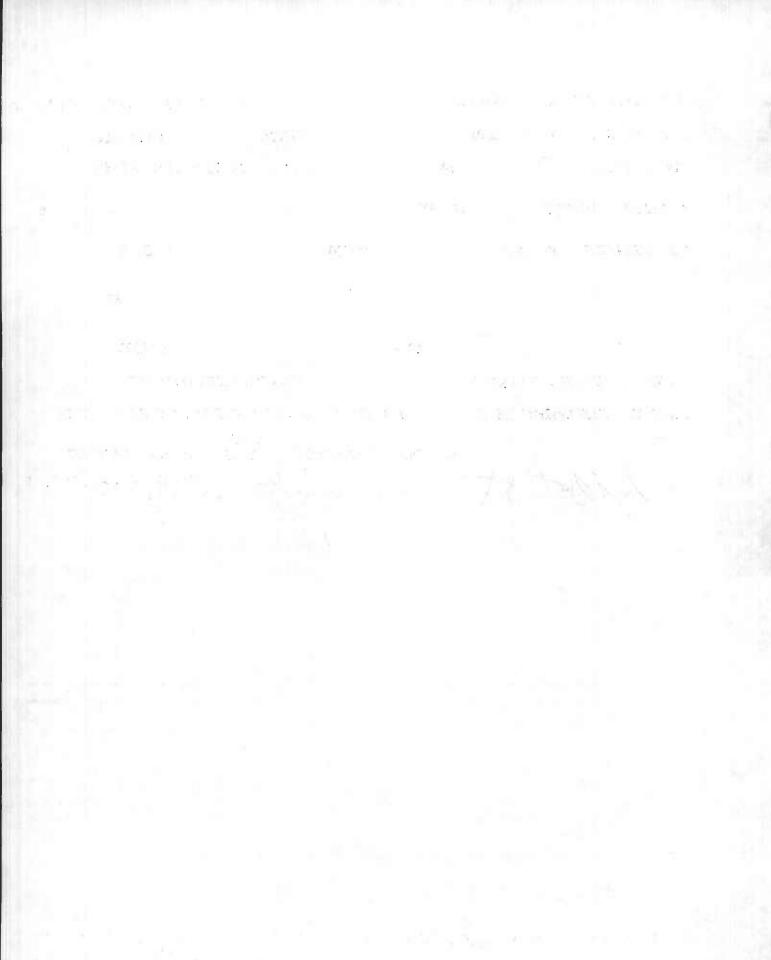
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Yeer) 30. Name and address of person who completed cause of death (flam 23a) (Type, Print) 10 Mark Kushner, MD. Prince Frederick, MD. 20678 32. Registrer's Signature State

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth **Physician** Month Yeer LAWRENCE FILDREN MARQUESS SEPTEMBER 4 1998 /Medical 8:05 AM 4e. Facility Neme (If not institution, give straat and number) 4b. City. Town, or Location of Deeth **Examiner** 4c. County of Deeth 1480 SKINNERS TURN ROAD OWINGS CALVERT 5. Sociel Security Number If Undar 1 Yaar if Undar 24 Hrs. Birthplece (Steta or Foreign Country) 7. Aga (In yrs. lest birthday) 8. Deta of Birth (Month, Dey, Yaer) **Funeral** Days 10M 2□ F Hours Yrs. Director 212-24-4212 74 MARCH 2,1924 MARYLAND the Maryland 10e State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at enter. MARYLAND CALVERT OWINGS Director 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? 1480 SKINNERS TURN ROAD 20736 U. S. A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Biack, Whita, etc. 1 ☐ Yes 2 ☐ No If Yes, Giva Yeer or Dates: 1 Navar Married 2 Married Baitimore, Maryland 21215-0020 1□Yes 2√2 No by 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 7 FARMER FARMING 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be LAWRENCE FILDREN MARQUESS NORA VIRGINIA COCHRANE 19e. Informant's Neme/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) HILDA MAE BUCKMASTER/SISTER 1480 SKINNERS TURN ROAD OWINGS, MARYLAND 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Mathod of Disposition 20c. Location - City or Town, Stete SEPT 1 Bunal 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 7,1998 MT. HARMONY CEMETERY OWINGS, MARYLAND 22. Name end Address of Facility LEE FUNERAL HOME CALVERT, 8125 SOUTHERN MARYLAND BLVD 3 OWINGS MD approximate Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sk, or heart failure. List only one cause on each line. **Physiclan** deno carcinoma /Medical Immediata Ceuse (Finel disaase or condition rasulting in death) Examiner Examine ein D Car physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseesa or injury that initiated events resulting in deeth) Last Due to (or es e consequance of): Box 68760. Physician/Medical Due to (or as a consequence of) 88 usa to signed by the a P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Wara sutopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? paga 2 s 1 Yes 2 No 1 □ Yes 2 □ No funaral director, 25. Wes case referred to medical exeminar? Be 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 27. Mannar of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: Affar 5 Pending investigation Attending after death. Director: Aft 1 Yes 2 No 2 Accidant tha 6 Could not be detarmined 3 ☐ Suicida Plece of Injury - At home, ferm, straat, factory, office building, etc. (Specify) 28f. Location (Straet end Number or Rural Route Number, City or Town, Steta) filled in by 4 Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as steted.
2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) end manner stated. 29a. Certifiar complataly (Check only one) within 2 To the I 29b. Signeture end title of certifier MD 29c. License number 29d. Dete signed (Month, Dey, Year) Mend Allendy Physic 30. Nema and address of person who completed cause of deeth (Item 23e) (Type, Print) 110 HOSP RD. 303 Shit ANWAR MUNSHI. M.D 31. Data filed (Month, Day, Year) 32. Registrer' Signeture

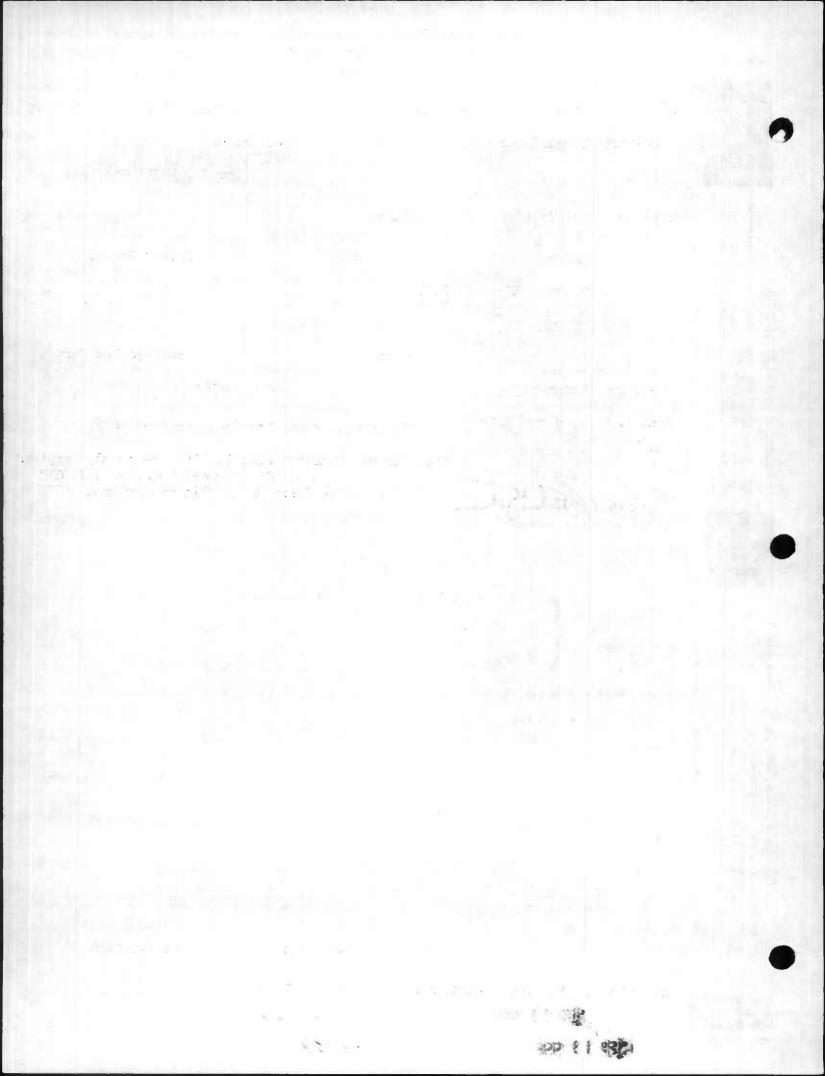
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State of Maryland / Department of Health and Mental Hygiene

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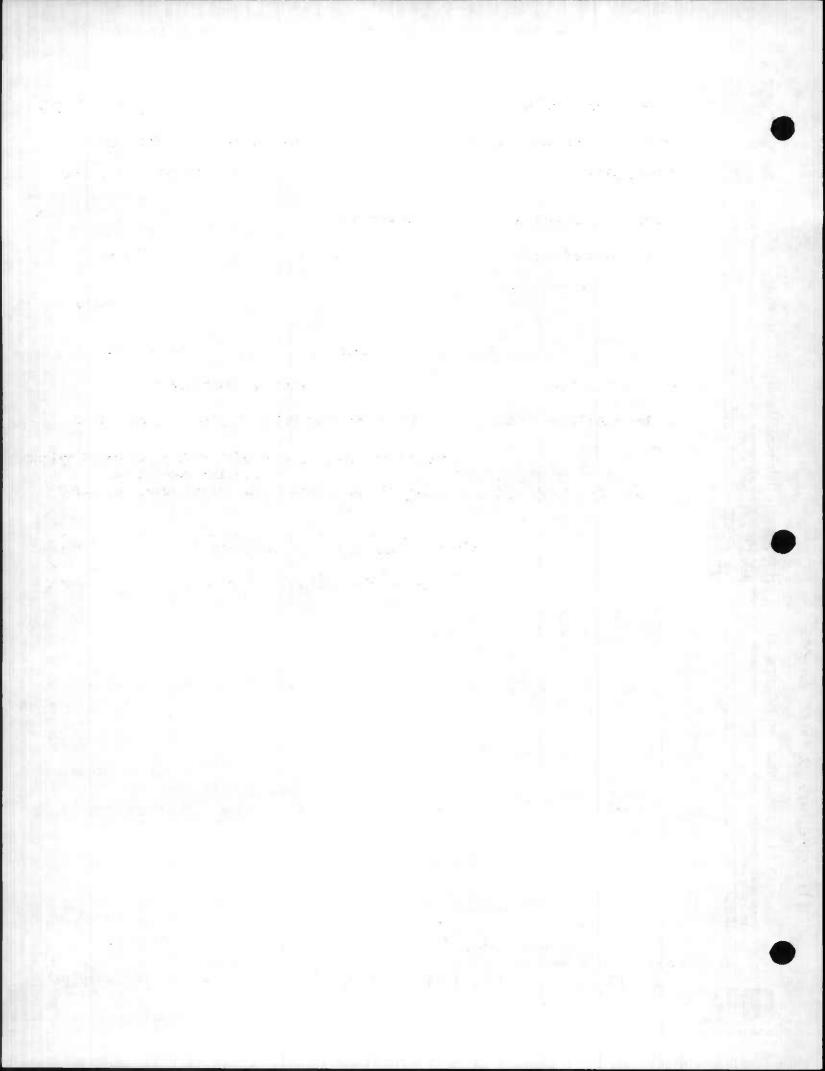


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Describe ho	n autopsymed?  es 22110  es 22110  es 6 Oth  ow injury occur  treet and Numb  n, Stete)  euse(s) end me  ate and placa,	3 Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of Production of	Vere eutopsy findings vellable prior to ompletion of cause f death?  Yes 2 No  Ify)  ral Route Number,  stated. to the cause(s)

Registrar

nicodemus, Elmer Evers



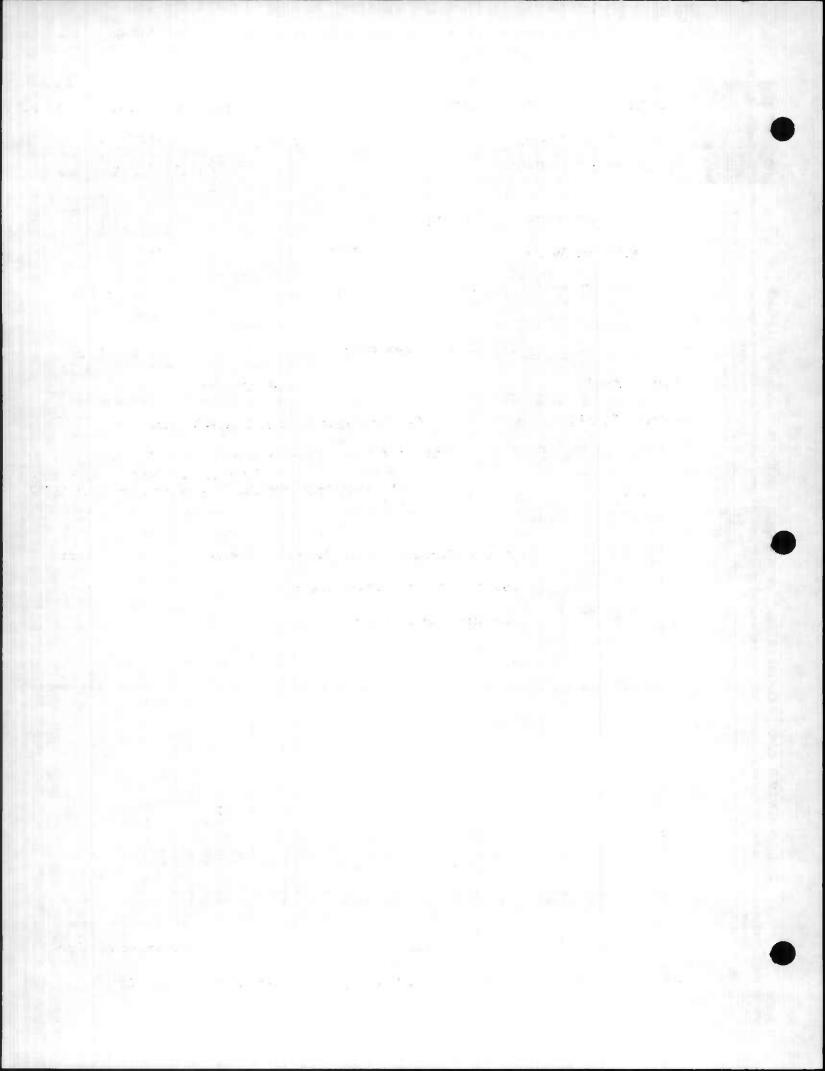
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ALETHEA MAGDALENE NIGH September 6, 1998 6:40 P.M /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 307 Garlinger Avenue Washington Hagerstown 8. Date of Birth (Month, Dey, Year)
July 10,1906 5. Social Security Number 7. Age (in yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1□M 2DE 219-66-1851 92 Yrs. Maryland Director Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland neat of Health end Mentel Hyglene.
nnt: If tem 27 is marked other than "naturel", or items 23s or 28s-f show nnt: If tem 27 is marked other than "naturel", or items 23s or 28s-f show nnt: If items and items of the trainmatic event, the Modest Exerting must be notified at 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 1⊠Yes 2□No Maryland Washington Directo Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 307 Garlinger Avenue 21740 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritat Status Black, White, etc. 1 ☐ Never Married 2 T Married White 1 Tyes 2 No Specify: p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Etementary/Secondary (0-12) Cotlege (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) David Eckstine Fannie Strock 19a. tnformant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Holland R. Nigh/Husband 307 Garlinger Avenue, Hagerstown, Maryland 21740 ce of Disposition (Neme of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny Injury or once. Rose Hill Cemetery - September 10,1998 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd.N., Hagerstown, Maryland 21742 23a. Parl Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a Arteriosclerotic Cardio Vascular Disease years Examiner Due to (or as a consequence of): Examiner and Diabetes Mellitus Type II vears physician end the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as e consequenca of): Division of Vital Records, P.O. Box 68760, and Carcinoma rectum Physician/Medical Due to (or as e consequenca of) 88 usa signed by the e 23b. Dfd tobacco use contribute to the cause of death? Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 1 Yes 2XXNo 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of cause of death? should b 24a. Was an autopsy performed? Completed irector, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: director, 25. Was cese referred to medicat examiner? Be 26. Piece of Deeth (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 PResidence 6 Other (Specify) To 1 Yes 2 No this 28a. Date of tnjury (Month, Dey Year) funeral 27. Manner of Deeth 28d. Describe how injury occurred 28c. tnjury at Work? 28b. Time of Certification: After 1 X Natural 5 Pending s effer des. 1 ☐ Yes 2 □ No investigation 2 Accident 6 Could not be 24 hours efter der ve Funeral Director pletely filled in by th 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide ó 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the cause(s) and manner as stated. edical 2 Medical Examtner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the To the To the Comple 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number dwel w Di Hove D01062 September 8, 1998 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) Edward W. Ditto, III, M.D. 217 W. Washington St. Hagerstown, MD 31. Date filed (Month, Day, Year) 32. Regištrar's Signature

**DHMH 16 Rev 6/95** 

State

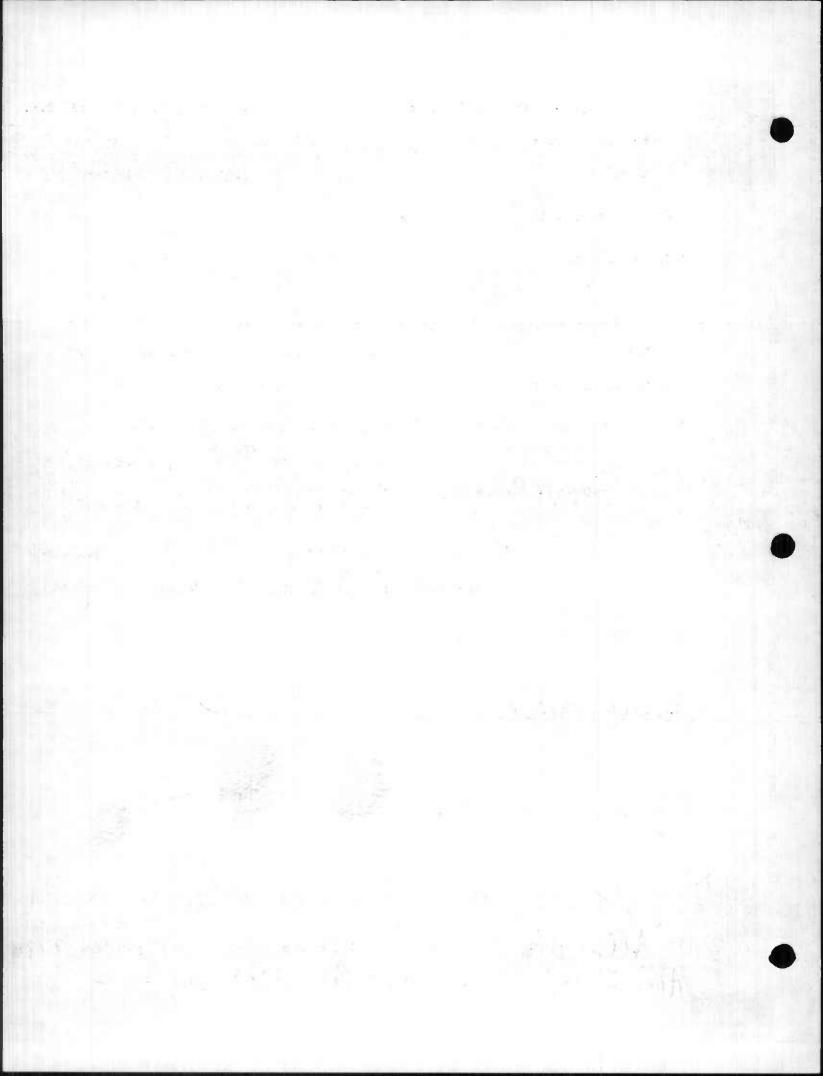
Registrar

SEP 09



State of Maryland / Department of Health and Mental Hygiene

						(	Certific	ate of	Death		R	eg. No.		.0150	
			leme (First, Middle,	Last)							Dete of Deel	th Day	Yeer	3. Time of Deeth	
	Physician /Medical		Mer:	Le Euge	ne New	come	r				ptemb			7:27 P.M.	
	Examiner	An Capilla, Nam	ne (If not institution,	give street end n	umber)				4b. City, Tow	m, or Location	on of Deeth	4c. Co	unty of Deeth	1	
A		Frede	rick Memo	rial Hos	spital				Frede	rick			Frede	rick	
	Funeral Director	5. Social Securi 220-34		Sex 1 M M 2□ F	7. Age (In yrs		monti rs.	der 1 Yeer hs Deys	If Under 24 Hours	Min. (	Dete of Birth Month, Dey 1y 13,	, Year)		nplece (State or Foreign untry) nesboro, PA	
	D 2	Usuel Residence	te of Decedent 10b. County		10c C	ity Town	or Location							10d. Inside City Limits	
	e Meryle Sa-f eho Effed at	79 20	Freder	ick		Churn								1 No 2 No	
	23e or 20	10e. Street end 5 Macin	tosh Dr.					Zip Code 217				U.S	of Whet Cou		
020	72 hours efter deeth with the Maryland natural", or items 23e or 28e-1 show used Examiner must be notified at steed by Furneral Director	11. Meritel State 1 □ Never N 3 □ Widowe	us Merried 2⊠ Marrie ed 4□Divorced	Armed F	2 □ No live	J,S.			Hispanic Origi an, Mexican, Specify:	in? (Specify Puerto Rica	Yes or No- in, etc.)		Reca - Amer Black, White becity: Wh	etc.	
5-0	"natural", polical Exp	(5	15. Decedent's Specify only highest	Education	0	16e. [	Decedent's U	suel Occup work done	pation during most o	of working		16b. Kind	of Business/Ir	ndustry	
Maryland 21215-0020	within see.	Elementary/S 12th	Secondery (0-12)		(1-4or 5+)				during most of d) Lntenar			Feder	al Gov	vernment	
p	other vent, is	17. Father's Ne	me (First, Middle, Li	ist)					18. Mother	's Neme (Fir	rst, Middle, I	Maiden Su	mem <i>e</i> )		
lar	should be nd Mental marked or matic eve		C. Newco	mer					M	lay P.	No11				
any	2 should and Men Is marker aumatic	19a. Informant	's Name/Relationshi	(Type, Print)		19b.	Meiling Addr	ess (Street	and Number	r or Rural Ro	ute Number	r, City or To	own, Stete, Z	ip Code)	
		Anna M.	Newcomer	(Wii	fe)	5	Macin	tosh	Dr., T	hurmor	nt. M	2.1	L788		
Baltimore,	20 50		2 Cremation 3		State	Placa of I cametery	Disposition ( cremetory	Neme of or other ple	rce)	Septe	ember	20c. Locat	tion - City or T		
altin	permit. Pege Department of Important: If any injury or page.		on 5 □ Other (Spendiscontinuous Lines)		Pr	ice'	22. Name	and Addre	emetery ess of Fecility	,		Wayne	esboro	, PA	
m	Depar Import	Jame			lersop		50 S	. Bro	eral H ad Str	eet. V	Navnes	sboro.	. PA	17268	
-	118.1	23a. Pert1. En	ter the diseese, or c heert feilure. List o	omplications that	caused the dea	th. Do no	ot enter the n	node of dyi	ng, such as c	cardiac or re-	spiratory err	est,		Approximate Intervel Between	
	Physician /Medicai	Immediate Cau	ıse (Finel	V	pach line.  Ontu	rula	h	bull	etron.				1	Onset end Deeth	
	Examiner	resulting in dea		0.	Due to	or es a co	onsequence	of):	٨		Λ			Years	
	ficete be executed physician and is the buriel-transit			<b>■</b> b. U	Ahero.	rcles	afre	lac	diova	sculo	v De	ure	_	gears	
	icete be executed physician and s the buriel-transit	Sequentially lis	t conditions, to immediate		Due to	or as a co	onsequence	of):					i	U	
9	be a sician burie	cause. Enter L Cause (Disease that initieted ev	e or injury	c									1		
x 68760,	2 5 2		ith) Lest	■ d	Due to (	or es e co	ensequence (	of):					E 0 0		
Вох	death ceine ettendir	1													
P.O.	the d	Rart II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Probables Melluhus									23b. Did tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown				
-	es thet igned be dete	Fac	NY LSIO	uni	)										
of Vital Records,	requir										24a. Was a perfor		6	Were autopsy findings eveilable prior to completion of cause of deeth?	
Re	The law ate hes b page 2 s										1 □ Y	es 201		I □ Yes 2 □ No	
tal	certificate rector, pag		eferred to medical						28. Plece	of Death (Ci					
>			Marie Section	Hospital:	Inpatient 2	RER/Out	netient 3	DOA Ot	hor				Other (Spec	cify)	
	eath. tor: After this the funeral di		Deeth 5 Pending	28e. Dete (Mo		28b. Ti	me of jury	28c. tnju Wo		28d.	Describe h			,,,,	
Division	the eat	2 Accide 3 Sulcide 4 Homici	6 Could no	t be 28e. Plac	ca of Injury - At ding, etc. (Spec		M m, street, fed		1165 2014	28f.	Location (S City or Tow	treet and N n, Stete)	lumber or Ru	ural Route Number,	
	To the Hospital or Att within 24 hours effer d To the Funeral Direct completely filled in by Medical Certifi		1 Certifying 2 Medical E	Physician: To the aminer: On the land ma	e best of my kn besis of examin nner stated.	owledge, etion end	deeth occuri or Investigat	red et the ti	ime, date end opinion, de <i>e</i> th	d placa, end h occurred e	due to the c	euse(s) en lete end pl	d menner es eca, and due	stated. to the cause(s)	
	Vithin To the comple		end title of cartifier	1				29c. Licen	se number		2	29d. Date s	signed (Month	h, Dey, Year)	
	->-0	DA.	Oct.	Ms				D2	6576			EP	TEME	ER 9 1998	
		30 Name and a	eddress of person w	Sours	use of death (Ite	om 23e) (1	Type, Print)	MA	F	RED	М	D	2170	2	
	State	31. Date filed (f	Month, Dey, Yeer)	1000	Registrer's Sign	nature	6.	Son	del						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Miriam Lenora 31, Newman 1998 August 6:10 P.M. /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 28 W. Water St. Smithsburg Washington If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months, Day, Year NOV. 1, 1917 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 10 M 20 F Months Yrs. 80 216-38-0122 Director Maryland Usuei Residence of Decedent death with the Maryland 10e. Stete 10b. County 10c. City. Town or Location show 10d. Inside City Limits ns 23a or 28a-f short Md. Washington Director Smithsburg 1 X Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 28 W. Water St. P.O. Box 158 21783 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ੴ No If Yes, Give Yeer or Dates: r than "natural", or items the Madical Examiner ma 11. Maritel Status Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. filed within 72 hours after 1 ☐ Never Merried 2 ☐ Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Proof Reader Book Co. 7 is marked other traumatic event, Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Pages 1 and 2 should be fill ment of Health end Mental H tant: If item 27 is marked out Be Frank W. Stouffer Mary A. Hershey 19a. Intorment's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zlp Code) permit. Pages 1 and 2 s Department of Health er Important: if item 27 is any injury or other trau once. John Michael Stouffer (Nephew) 13733 Frank's Run Rd. Smithsburg, Md. 21783 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2X Cremetion 3 ☐ Removel from 5 Other (Specify) ithsburg Crematory Sept. 3, 1998 Smithsburg, Md. Signeture of Funeral Service Licensee 22. Name end Address of Fecility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 234 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respishock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel diseese or condition resulting In deeth) /Medical Acute Myocardial infarction instant Examiner Due to (or es e consequence of) Examiner Arteriosclerotic Heart Disease 1 year or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the ettending physician end Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest pue buriel-trar Due to (or es e consequence ot): Box 68760. Physician/Medical 单 Due to (or es e consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the causa of death? the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Chronic obstructive Pulmonary Disease þ 90 24b. Were eutopsy tindings aveilable prior to completion of cause of deeth? 24e. Wes en eutopsy Completed Bronchial Asthma 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was cese reterred to medicel exeminer? 26. Piece of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Certification: To Other: 4□ Nursing Home 5 🗵 Residence 8 □Other (Specify) 1 ☐ Yes 2 ☒ No 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 Could not be determined 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital c within 24 hours at To the Funeral D completely filled is 1 Cartifying Physicien: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner steted. Medical 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Yeer) D07857 09/01/1998 May Magy

DHMH 16 Rav 6/95

State

Registrar

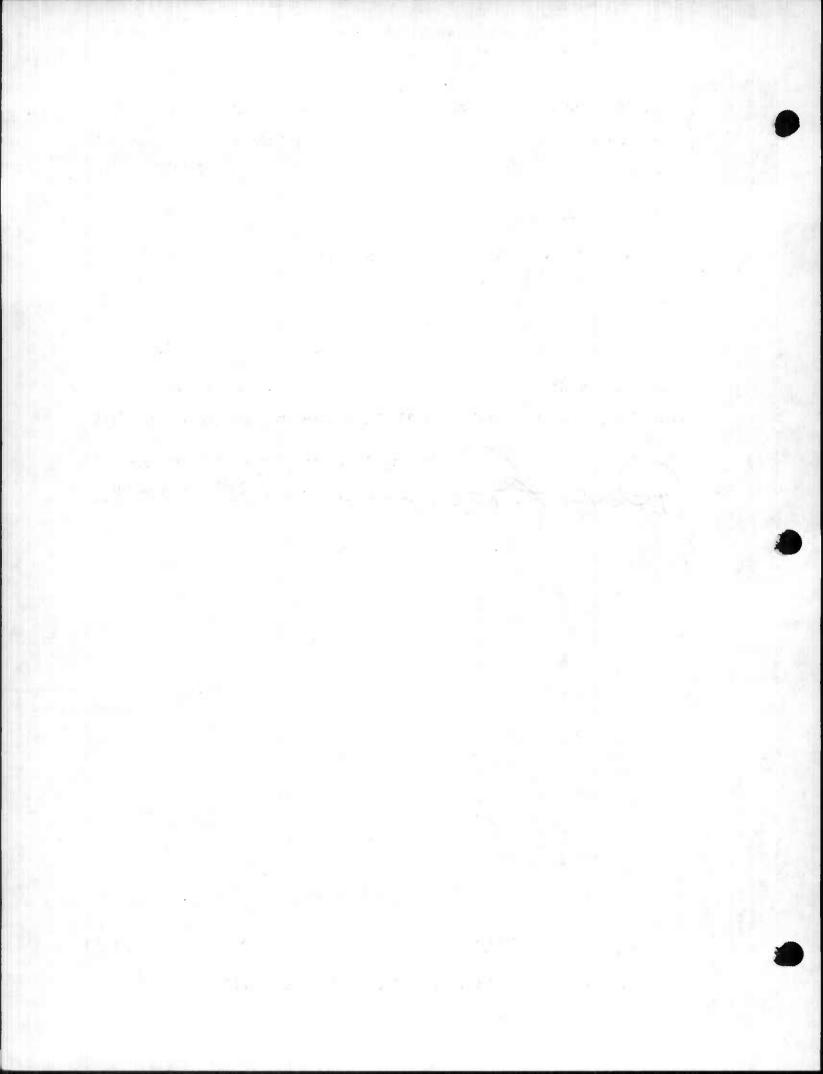
30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

SEP 02 1998

31. Dete tiled (Month, Day, Year)

Edson B. Moody M.D. 1190 Mt. Aetna Rd. Hagerstown, Md. 21740

32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2300 SEPTEMBER 6, 1998 NAGY Jr. **ALEXANDER** /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE FREDERICK CALVERT MEMORIAL HOSPITAL CALVERT If Under 1 Months 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1₽M 2□F Director 198-09-0924 Usual Residence of Dece DFC. 26,1910 HUNGARY the Menylend 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Meryler Department of Health and Mental Hygiena. Important: If Item 27 is merked other than "natural", or Items 23s or 28s-f show eny Injury or other traumstic avent, the Medical Examines must be notified as 1 ☐ Yes 2 ☐ No Director MARYLAND CALVERT DUNKIRK 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code S. A. Funeral 4105 PATUXENT COURT 2075412. Was Decedent Ever in U,S. Amped Forces? 163 Yes 2 □ No It 4 Pes, Give Year or Dates: 141-145 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 000 Baitimore, Maryland 21215-0020 Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Graphic Artist U. S. Air Force 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROSE BALOGH ALEXANDER NAGY, SR. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) ELLEN H. NAGY / WIFE 4105 PATUXENT COURT DUNKIRK, MARYLAND 20754 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Department | 2 Cremation | 3 Removel from State | 4 Donation | 5 Other (Specify) Cedar Hill Cemetery 11,1998 Suitland, Maryland 21. Signature of Funerat Service Licenses 22. Name and Address of Facility LEE FUNERAL HOME CALVERT, P.A. 8125 SOUTHERN MARYLAND BLVD. OWINGS, MD 20736 Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart teilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediete Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of) Examin physician end the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as/a consequence of): Box 68760 an/Medical 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. signed by a 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings evailable prior to completion of cause of deeth? 24a. Wes an autopsy performed? Completed certificate hes 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ PR/Outpatient 3 ☐ DOA 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 this 28a. Date of Injury (Month, Day Year) e Hospital or Attending Ph n 24 hours star deeth. e Funeral Director: After th 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 DNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier completely (Check only one) To the To the To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) 0+1 Prince Frederick, Maryland Dr. Mahesh P Shah, M.D.

**DHMH 16 Rev 6/95** 

State Registrar

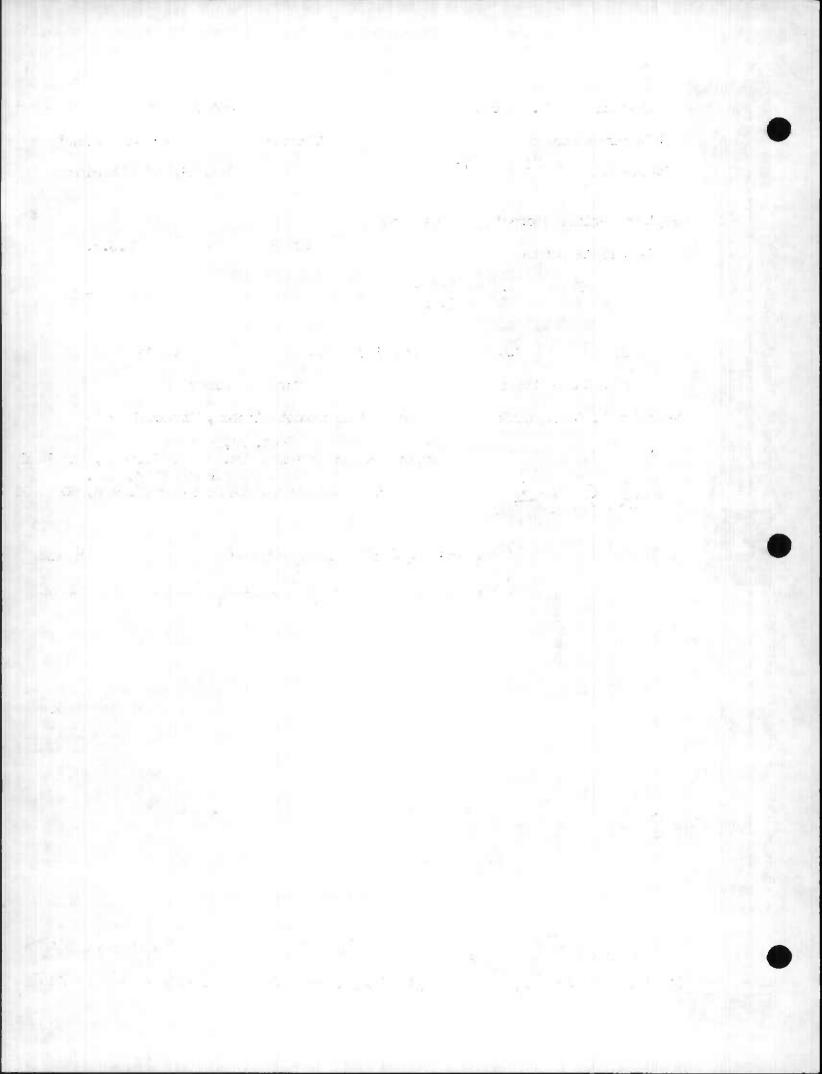
31. Date filed (Month, Day, Year)

32. Registrarfé Signature

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 11:56 am Charles W. Ogden Sept 8, 1998 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 5410 Plata Street Clinton Prince George's 8. Date of Birth (Month, Day, Year) June 19,1920 5. Social Sacurity Number If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Yrs. 579-10-4992 Director Washington DC Usual Rasidance of Decedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s and 2009. 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Directo Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 20735 U.S.A. 5410 Plata Street Funeral Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Biack, Whita, etc. 1 Nevar Married 2 Marriad 1 Yas 2 No Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Collega (1-4or 5+) N/A Elamantary/Secondary (0-12) Graphics Branch GSA Retired 18. Mothar's Nama (First, Middla, Maiden Sumame) 17. Father's Nama (First, Middle, Last) Charles Jesse Ogden Mary Carev 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. informant's Name/Ralationship (Type, Print) Voichita N. Ogden (Wife) 5410 Plata Street Clinton, Maryland 20735 20b. Place of Disposition (Nama of cematary, cramatory or other place) Sept. 1Pat 998 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 XBurial 2 Cramation 3 Ramoval from Stata Maryland State Veterans Cem. Cheltenham, Maryland 4 Donation 5 Othar (Specify) 22. Nama and Addrass of Facility Lee Funeral Home, Inc. 21. Signatura of Funaral Service Licensae 6633 Old Alexandria Ferry Rd Clinton, MD 20735 Part . Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death **Physician** /Medical immediata Causa (Finel disaasa or condition rasulting in daath) Examiner Physician/Medical Examiner and I-trensit law requires that the death certificete be executed Sequantially list conditions, if any, laading to immediata causa. Entar Undarlying Causa (Diseese or Injury that initiated evants physician ar Division of Vital Records, P.O. Box 68760, Dua to (or as a consequence of): rasulting In daath) Last 88 esn. 23b. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. the signed by t 1 Yes 2 No 3 Probably WUnknown þ 24b. Were autopsy findings available prior to 24a. Wes en eutopsy performed? Completed peen completion of ceusa of death? page 2 s The 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director Be 25. Wes cesa referred to medical 26. Placa of Daath (Check only one) Othar: 4 Nursing Homa Standance 6 Othar (Specify) 2 15 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28e. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Panding death. 1 ☐ Yas 2 ☐ No Invastigation Il Director: / 2 Accidant 6 Could not be datarminad 3 ☐ Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify) in 24 hours the Funeral Direct the Funeral Direct 4 Homicida Hospital edical 29a. Cartifian 🌠 Certifying Phyaician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, data and place, end due to the ceuse(s) and menner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. Licanse number 29d. Data signed (Month, Day, Year) 0 D16129 Neme and eddress of person who f death (Item 23e) (Type Print) Pd#600 Clinton MD 20735 9131 liam J Viscataway 31. Deta filad (Month, Day, Year) 32. Registrar's Signatura State 1998 **SEP 10** Registrar

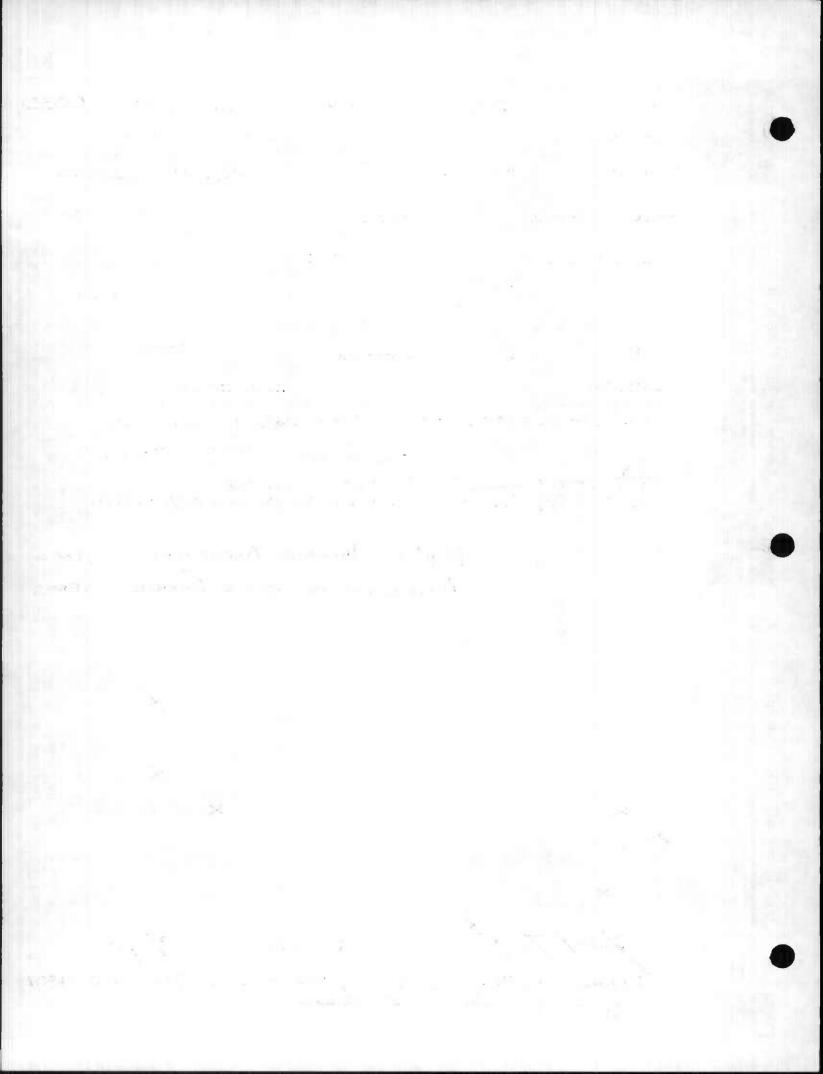
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State of Maryland / Department of Health and Mental Hygiene 98 28794

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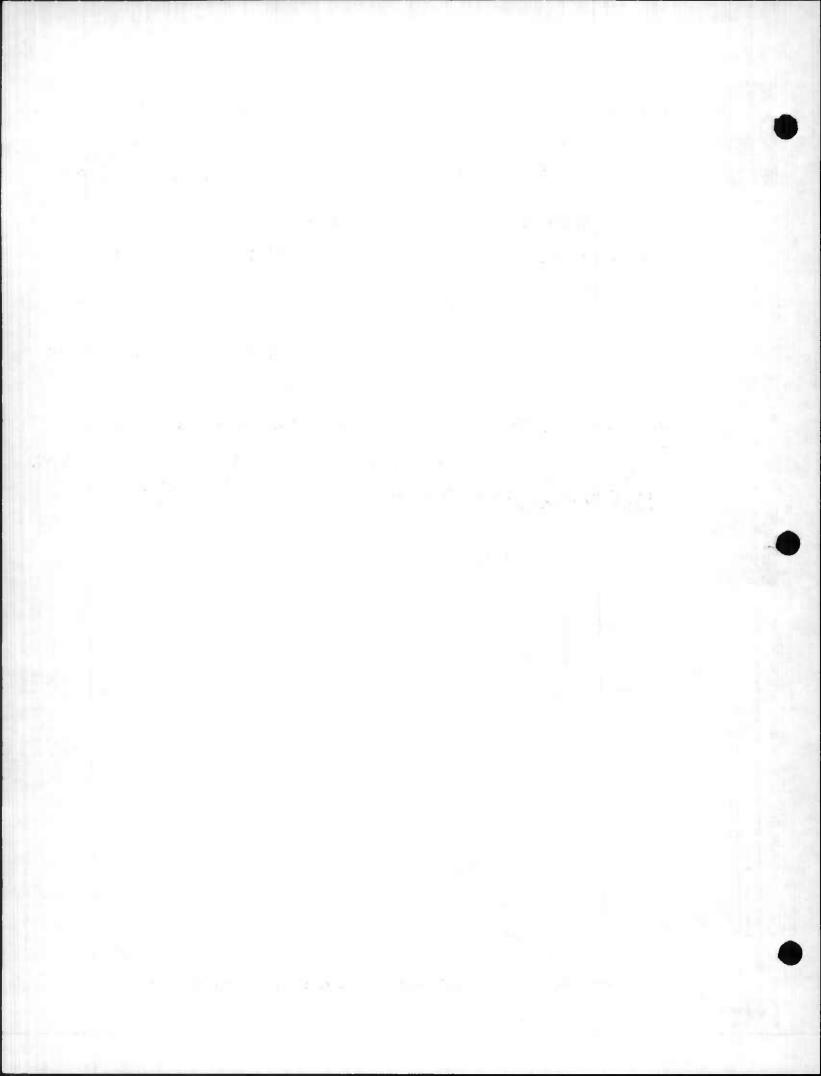
Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SEPTEMBER 0, 1:40 P.M. 1998 EARL LISTON PHILLIPS /Medical 4a. Facility Neme (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 57 SOUTH MAIN STREET BOONSBORO WASHINGTON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□ F 214-28-0665 Yrs Director MARYLAND Usual Residence of Deceden the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Director MARYLAND WASHINGTON BOONSBORO 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6 **items** 23e 57 SOUTH MAIN STREET 21713 U.S.A. Examiner name Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No 1945-If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinations. 1 ☐ Never Married 2 M Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) DISTRIBUTION SUPERVISOR FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maideri Sumeme) Be EARL B. PHILLIPS FLORA SHAWEN 19a. Informant'a Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) DOROTHY PHILLIPS/SPOUSE 57 SOUTH MAIN STREET, BOONSBORO, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/11/98 BOONSBORO CEMETERY BOONSBORO, MARYLAND 21. Signature on Funeral Service / Iconasse 22. Neme end Address of Fecility 7606 Old NationalPike Paul M. Dean BAST FUNERAL HOME Man Boonsboro, MD 21713 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner rose Due to (or as a consumuence of): Examiner Hospital or Attending Physician: The law requires that the death cartificate ba assocuted physician end the burial-transi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as e consequence of): usa as Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 □ Yes 3 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Hesidenca 6 □Other (Specify) 1 Yes 2 No Certification: To this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 □ Natural 2 □ Accident 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completally filled in by the fun 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end manner as stated.

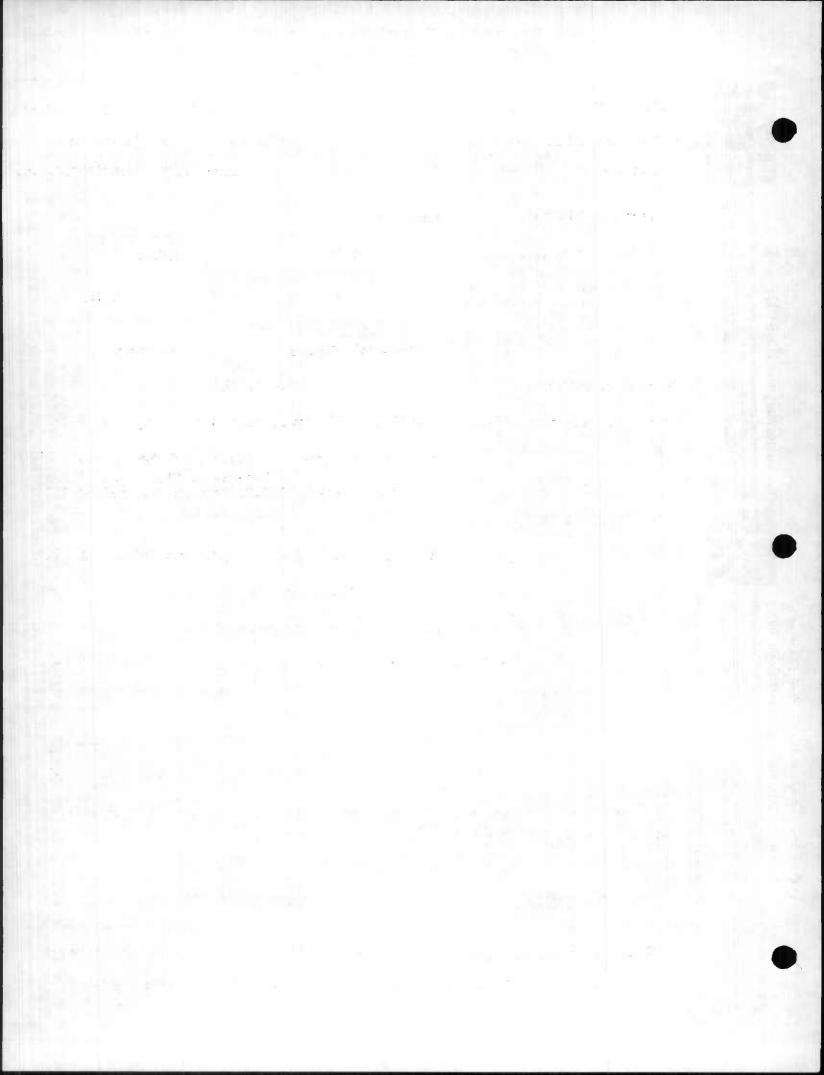
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner steled. 29a. Certifier Medical 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32518 110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. Guedent, M. D. 100 Geeting Lane, Keedysville, M. 21756 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 09 Registrar



State of Maryland / Department of Health and Mental Hygiene

					C	ertifica	ite of	Death		Reg. No.	-	0150		
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Physicia /Medica	_	Keith Howard P	attersor	1					augus		1998	15:47 AN		
Examine		4a Facility Neme (If not institution, giv	e street and number;	)		-1-		4b. City, Town, or			of Death			
		Union Memorial	Hospita	al				Baltim		Balti		City		
Funeral Director		5. Sociel Security Number 6. S 218-50-2899	Sex 7. Ag	ge (In yrs. I	ast birthda 1 Yrs	Month	er 1 Year S Days		8. Date of Bi (Month, D March	31,1957	9. Birthpl Coun Washi	lace (State or Foreign try) ngton, D.C.		
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23a th	a l	1011 Oak Hill Ave	enue			2	1742			U.S.A.				
after dea	une	11. Maritel Status	12. Was Decedent Armed Forces	Ever In U.	S. 1	3. Was Dec	adent of l	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or N to Rican, etc.)	- 14. Rac Blac	e - Americ ck, White,			
5-0020 72 hours after death with the Maryland natural', or flame 23s or 28s-4 show diese Examples must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:			1 ☐ Yes				Specify	w Whi	.te		
15-00°	ted	15. Decedent's Ed (Specify only highest gra	ducation		16a. De	ecedent's Us	ual Occu	pation during most of wo	orkina	16b. Kind of B	usiness/inc	dustry		
within within then.	Completed	Elementery/Secondery (0-12)	College (1-4or	5+)										
d 21: Higher with mit, the	Co	12	4		Fin	ancia	I PIa			Insura				
Maryland 2 d 2 should be filed th end Mental Hygi 7 is marked other traumatic avent.	Be	17. Fether's Name (First, Middle, Last,								, Maiden Suman	18)			
aryla should I marka umaric i	2	Raymond C. Patter	rson						. Kinke					
Aarylan		19a. Informant's Name/Relationship (Type, Print)  19b. Meiling Address (Street and Number or Rurel Route No.												
re, N s 1 end 3 f Health them 27 l		Shelby A. Patterson/Wife 1011 Oak Hill Ave., Hagerstown, Maryland												
Baltimore, Maryland 21215-0020 pernit. Peges 1 end 2 should be filed within 72 hours aft Department of Health end Mental Hygiena. Important: If Item 27 is marked other than "natural", or any injury or other traumatic avant, the Medical Examples.		20a. Method of Disposition  1 🖾 Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of cametery, crematory or other placa)  Rest Haven Cemetery  Aug.31,1									20c. Location - City or Town, State 1998Hagerstown, MD 217			
Balti permit. Departmineorta importa any Inju		21. Signature of Funeral Servica Licar	nsee					ess of Facility Do				cal Home and 21742		
										•	ргата			
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/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. PROFOUND Bradycandia and Ventacular 7, In Intra-  Due to (or es a consequence ot):												
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ed sit	- P	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last  Due to (or es a consequenca of):  Due to (or as a consequenca of):  Due to (or as a consequenca of):										I mos,		
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X 60 X Ging p ding p sa es	ĕ		a Vent	ical	an	Sept.	il	le feet	_			41 year		
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Divisi	Ē	3 ☐ Sulcide 6 ☐ Could not b 4 ☐ Homicide determined	286. Piece of in	ijury - At ho tc. (Specify		, street, fact	ory, office		28f. Location City or To	(Street and Numi wn, State)	ber or Rura	I Route Number,		
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o thing	Me	29b. Signature and title of cartifier				2	9c. Licer	se number		29d. Date signe	ed (Month,	Dey, Year)		
->-		Dm O Q					2001	20888		A	2 7	1000		
		30. Name and address of person who	completed cause of	death (Item	23e) (Tu		0006	20888		11-9-57	4/	1775		
		Peter J. Sloane, n	2227	A	Calva		+ #	650 Bo	altimor	- mn	21	218		
State		31. Date filed (Month, Day, Year)	32. Regist	rar's Signe		,	,	_ , , , , ,						
Registra		AUG 3 1 19	98 120	una.	19	· de	Dock	21						

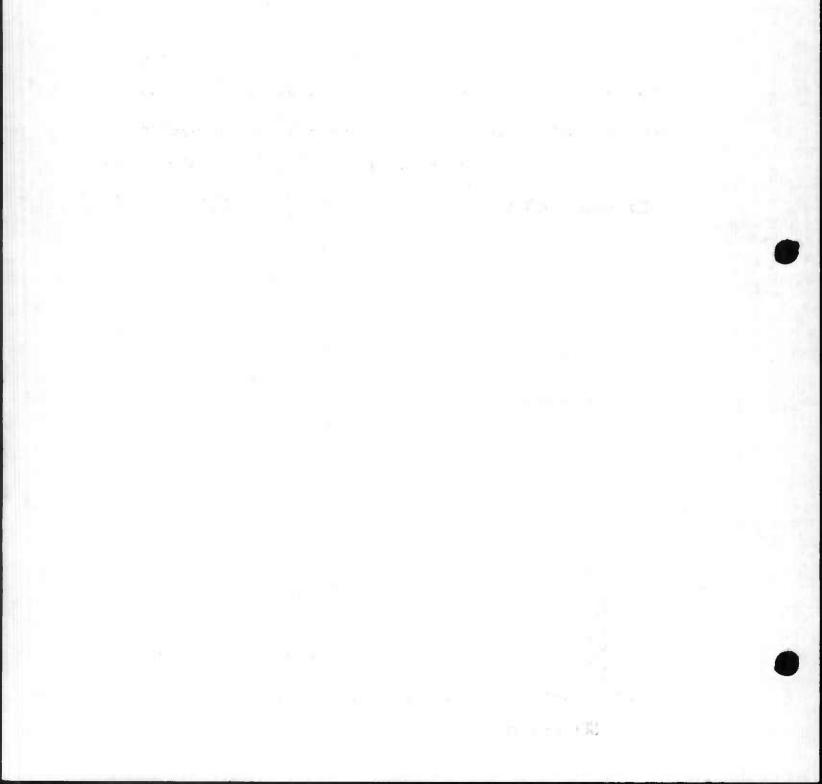
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State of Maryland / Department of Health and Mental Hygiene

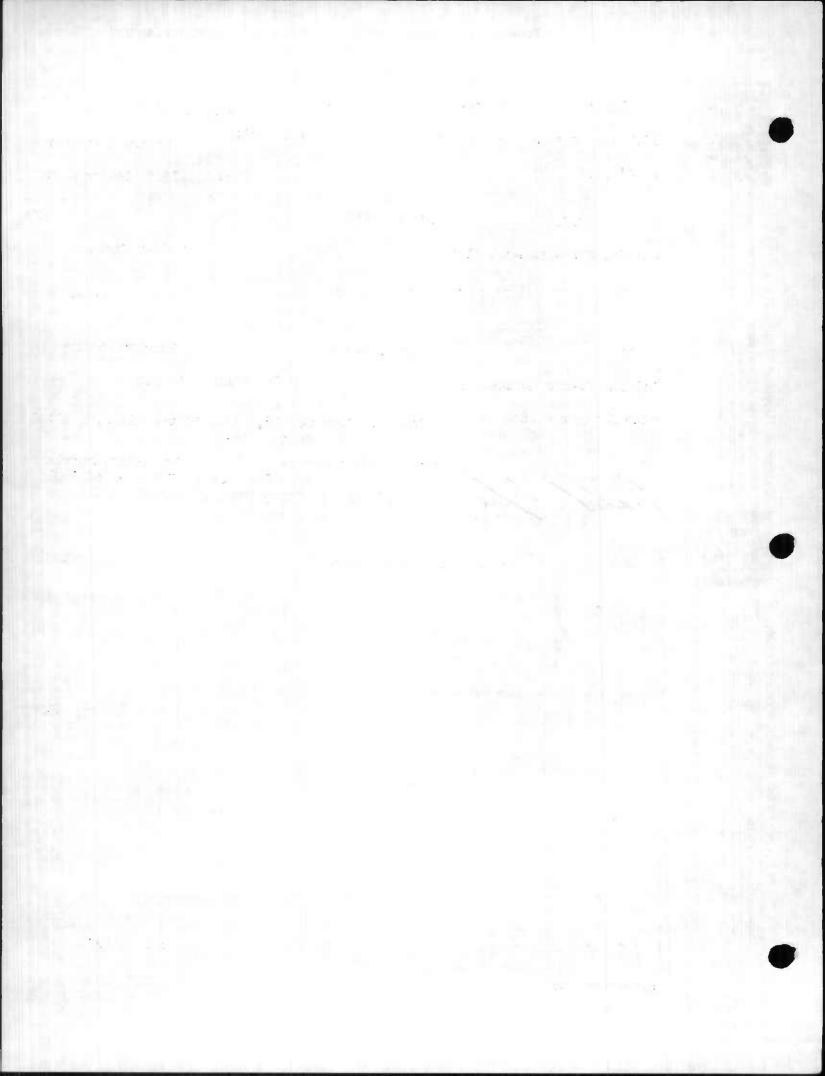
Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1998 September 1950 Georgina Anastasia Perez /Medical 4a. Facility Name (If not institution, give street and number, Calvert Memorial Hospital 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Frederick Calvert 7. Age (In yrs. lest birthday) If Under 1 Year | If Under 24 Hrs. Months | Deys | Hours | Min. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys 1 □ M 2 ☑ F Director 071 36 5799 January 22 1940 Cuba Usual Residence of Decedent with the Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at Maryland Calvert Lusby 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 782 Wild Cat Trail 20657 United States death Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 Yes 2 No If Yes, Give Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Maritei Status a filed within 72 hours efter il Hygiene. other than "natural", or the 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 Yes 2 No SpecifyCuban Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) housewife own home permit. Pages 1 end 2 should be file Department of Heeith and Mental Hy Important: If item 27 is marked other any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Carlos Perez Delia R. Miranda Alvarez P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Figiel-daughter 782 Wild Cat Trail Lusby Maryland 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. 8 1998
Metropolitan Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlel 2 ☐ Cremation 3 ☐ Removel from State Alexandria Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerei Service Licansee 22. Name end Address of Feclity Rausch Funeral HOme PA 4405 Broomes Is. Rd. Port Republic Maryland 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Physician immediate Cause (Final disease or condition resulting in death) /Medical Examiner Carcinosarcoma of uterus 10 months Due to (or as a consequence of). Physiclan/Medical Examiner physician and the bunal-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequença of): Box 68760. Due to (or es a consequence of): 88 ettending p 950 P.O. ed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 420 Unknown signed t Records, þ been signated 24b. Were autopay findings evailable prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed page 2 s has 1 ☐ Yes 2 DXNo 1 TYes 2 No certificate Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2K No Certification: To 1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA this funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury occurred Aftar s effar de... 1 Delatural 5 Pending Investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 4 Homicide within 24 hours eff.
To the Funeral Dir
completely filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) end menner as ataled.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) end menner stated. 29a. Certifier edical (Check only one) To the within 2 29b. Signature entitle of entitler 29c. License number 29d. Date signed (Month, Day, Year) D 29657 9/6/98 person who completed cause of death (Item 23a) (Type, Print) 30. Name and addr Dr. Charles Judge, M.D. Prince Frederick, MD 20678 32. Registrar Signeture 31. Date filed (Month, Day, Year) State Registrar 0 × 1998



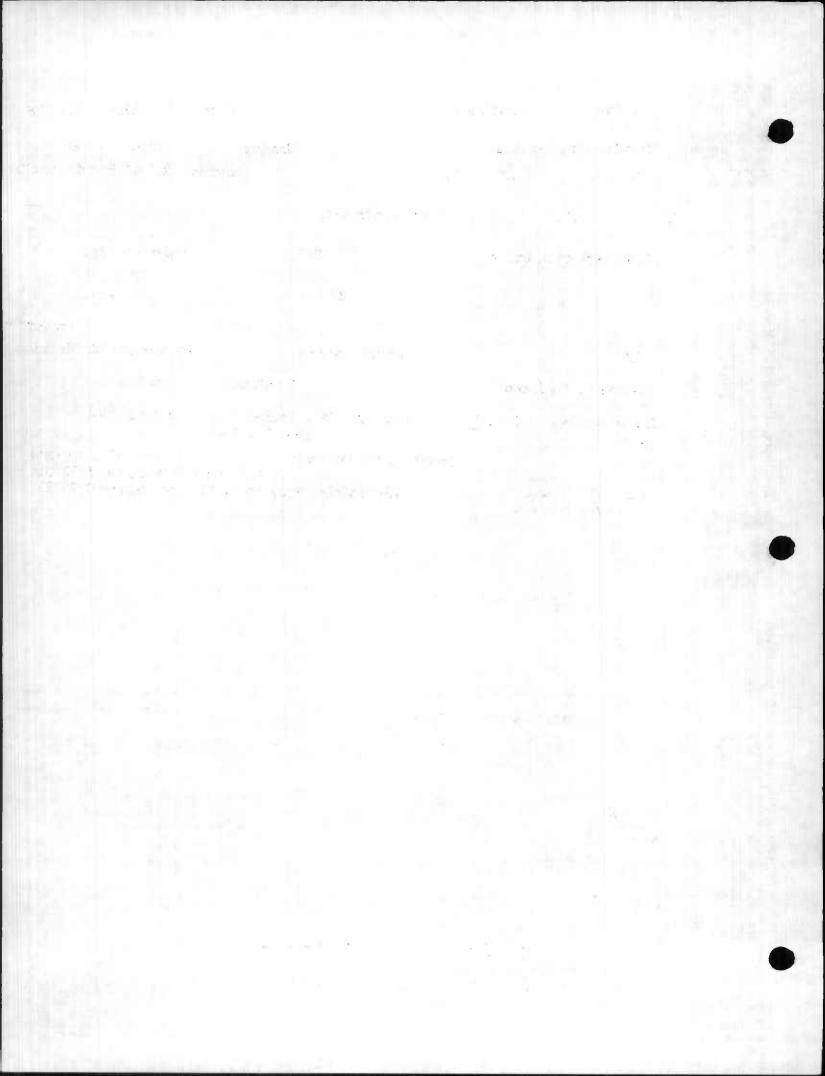
State of Maryland / Department of Health and Mental Hygiene

			Certi	ificate of	Death		Reg. No.	1.0	2010		
	1. Decedent's Name (First, Middle, La	est)				2. Date of D	eath Day	Year	3. Time of Dea		
Physician /Medical	William	Morris	Rutt	ter, Jr.		Sept			1:11		
Examiner	4a Facility Name (If not institution, gi 3849 St. Barna	bas Road # 10			th 4c. County Prince	County of Death rince George's					
Funeral Director		Sex 7. Age (In y)  1. Age (In y)  62		If Under 1 Year Months Days	If Under 2 Hours	Min. (Month, E			ace (State or For ry) non, Pa		
M W	10a. State 10b. County	10c.	City, Town or Loca	tion				10	d. Inside City Lir		
to of	MD P.G.		Silver I	Hill					1 ☐ Yes 2 🔀		
3a or 28u m be not	10e. Street and Number 3849 St. Barnab	as Road #104		10f. Zip Code 207	46		10g. Citizen of V United				
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ted first	15. Decedent's E (Specify only highest gr		16a. Deceder	nt's Usual Occup	pation during most	of working	16b. Kind of B	usiness/ind	ustry		
ygiene.  To than "naturel", of the Made Example Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DC	(Give kind of work done during most of life. DO NOT use retired)  Cartographer			Maryla	ryland State			
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alth end A	19e. Informent's Name/Relationship Helen Eleanor F	autter	3849 S	t. Barn	abas R	d, #104,	Number, City or Town, State, Zip Code) , Silver Hill ,MD 20				
ment of He lant: If item jury or oth	20a. Method of Disposition  1 X Virial 2 Cremation 3 ( 4 Donation 5 Other (Special Control Con	(y)	Place of Disposit cemetery, crema	oln Cem	Brentw	entwood, Marylandome,Inc 6633 Old					
Dependimport	21. Signature of Funda Shruigh Lice	mon //Le				Lee Funera y Road, C					
hysician	23a. Part1. Enter the disease, or con shock, or heert failure. List only	nplications that caused the de one cause on each line.	eath. Do not enter	the mode of dyi	ng, such as c	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Deat		
/Medical examiner	Immediate Cause (Final disease or condition resulting in death)	a. Metastati	c Lung (or as a conseque	Cancer enca of):					Months		
ng physician end e es the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequenca of):  Due to (or as a consequenca of):										
e ettendi ed for us	Dark II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Dfd tobacco use contribute to										
ned by the detacher						☐ Yes 2☐ No 3☐ Probabity 4☐ University					
20 0			140			24a. Wa	is an autopsy formed?	ava	ere eutopsy findir alleble prior to mpletlon of cause death?		
certificate has rector, page 2						10	Yes 2 No	10	Yes 2□ No		
ertifice actor, Be C	25. Was case referred to medical examiner?				26. Place	of Death (Check only	one)				
this certific ral director, To Be	1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient	3□ DOA Ot	her: 4 Nur	sing Home 5 Re	sidenca 6 □Ott	ner (Specify	1)		
within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page  Medical Certification: To Be Com	27. Manner of Death 1 ENatural 5 Pending 2 Accident investigation		28b. Time of tnjury	28c. Inju Wo M 1	lo	28d. Describe how injury occurred					
within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not l	28e. Plece of Injury - A building, etc. (Spe	t home, farm, stree ocify)	t, factory, office		28f. Location City or T	n (Street and Number or Rural Route Number, Fown, Stete)				
within 24 hours To the Funeral completely filled		hysician: To the best of my k miner: On the basis of exami and manner steted.					e, date end placa,	and due to	tha cause(s)		
To the common Name	29b. Signature and title of certifier	Pd.		29c. Licen	se number 9391		29d. Date signe Sept		111-		
	1))		_	4, 1998							
	30. Name and address of person who Dr. Redjace, MD	completed cause of death (I	tem 23a) (Type, Pr			ls, Maryl	- 7 0074	0			



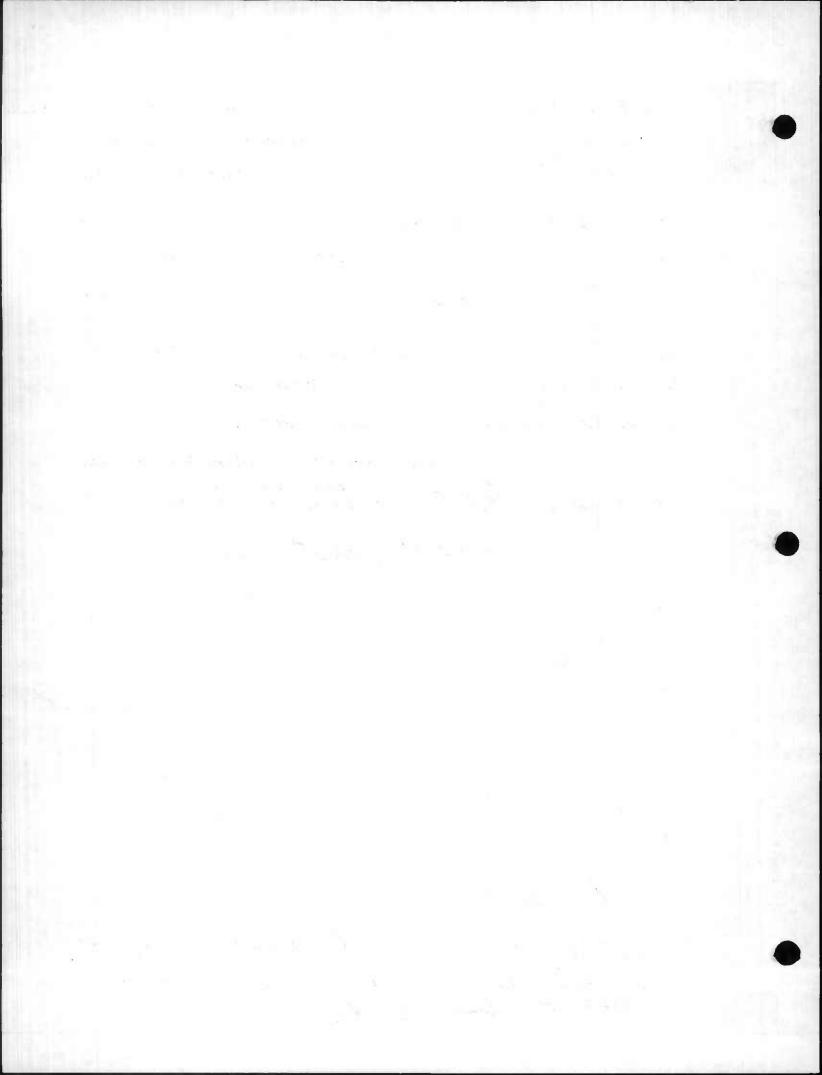
State of Maryland / Department of Health and Mental Hygiene

		Otate of Mary		ertifica				Reg. No.	4	0199
Physician	1. Decedant's Nama (First, Middla, La	ast)					Data of De Month	ath Day	Year	3. Time of Death
/Medical	Ashline	Robinson				1 O' T	Sept.		998	10:05PM
Examiner	4a Facility Nama (If not institution, give	va street and number)				ib. City, Town, or	Location of Deat			
Fuercial	Pineview Nursi 5. Social Security Number	ng Home 7. Age (Ir	n yrs. last birtho	lay) If Und	lar 1 Year s Days	If Under 24 His	8. Dafa of Bir	Princ	e Geo	orge aca (Stata or Foraign
Funeral Director	579 20 8558 Usual Rasidanca of Dacedant	Octobe	r 22,192	21 Was	aca (Stata or Foraign ShingtonDC					
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or 28	10e. Street and Number			10f. Z	ip Coda			10g. Citizen of V		
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Fu Pre	11. Marital Status  **Mevar Married 2   Married 3   Widowed 4   Divorced	12. Was Dacedant Eval Armed Forcas? 1  Yas 2000 of Yas, Giva Year or Datas:	r in U,S.		2 22 2	ispanic Origin? ( an, Maxican, Pua Specify:	Specify Yes or No rto Rican, atc.)	Specify	AATT	ite
	15. Decedant's E (Spacify only highast gr	ducation	16a. D	ecedant's Us	ual Occup	ation during most of we	ndkina	16b. Kind of Bu	usiness/Ind	Governme
ithin "r	Elementary/Secondary (0-12)	College (1-4or 5+)			-					C District
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2 should be filed with end Mental Hygiena. Is marked other than surradic svent, treat To Be Comp	17. Fathar's Nama (First, Middla, Last Ashton M. Rob					Const		Cordi		
2 should 1 smerker surretter	19a. Informant's Name/Ralationship		19b. N	lailing Addre	ss (Straat	and Number or F	Rural Routa Numb	er, City or Town,	Stata, Zip	Coda)
	Elmira Staples	(SISTER)	P.	O. Box	399	, India	n Head,	Maryland	206	40
permit. Pages 1 and 2 should be filed within 72 ho Depertment of Health end Mental Hygiena. Important: If Item 27 is marked other than "natur any injury or other traumetic svent, in Healcal once.  To Be Completed	20a. Method of Disposition  1	Hamovai from Stata	Port Li	ncoln	Ceme	terv	1	20c. Location - Brentwo	ood,	Maryland
ortant:	21. Signatura of Funaral Sarvica Lica			22. Nama	and Addra	ss of Facility I	ee Funer	al Home	,Inc	6633 Old
Depentit. Depenting	1 5t. 8. 52	#		Alexar	ndria	Ferry F	Road, Cli	nton, Ma	rylan	d 20735
Diamaia i a i a i	23a. Part1. Entar the disaase, or con shock, or heart failura. List only	nplications that causad that ona cause on each line.	daath. Do not	antar the m	oda of dyir	ng, such as cardia	ac or respiratory a	rrast,		Approximate Intarval Batween Onsat and Death
Physician /Medical	Immediata Causa (Final disaase or condition		C. C	ocia					1	Weeks.
Examiner	resulting in death)	aDue	to (or as a con	nsequence o	f):					10000
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and and I-trens	Sequentially list conditions,	Dua	to (or as a cor	nsaquance o	f):					
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d for	Part II. Other significant conditions	contributing to death but no	ot resulting in th	a undarlying	n cause niv	an In Part I.	23b. Did	tobacco use co	ntribute to	the cause of death?
as that the death cert gned by the attendin be detached for use by Physician/M				1 Yes 2 No 3 Probably 4 Unknow						
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should leted	FI	Der a	VA.	De	me	ma		an autopsy ormed?	ava	era autopsy findings allable prior to mplation of cause death?
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certificata has rector, page 2	25. Was case refarred to medical axaminar?						eath (Check only	ona)		
Physician: ribls certificatel director, TO Be (	1 ☐ Yas 2 ☐ Po	Hospital: 1 Inpatient	2 ER/Outp			4 LOUNUISING	Homa 5□ Ras			1)
ding Pi h. After ti funera	27. Mannar of Death  1 Natural 5 Panding 2 Accidant Invastigation	28a. Data of Injury (Month, Day Ye	ear) 28b. Tin Inju		28c. Injur Wor	yat k? Yas 2 □ No	28d. Dascribe	how injury occur	red	
To the Hospital or Attending Physician: The lav within 24 hours eftar death. To the Funeral Director: After this certificata has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	3 Sulcida 6 Could not l 4 Homicida datarmined		- Af homa, farm Specify)	, straat, fact	ory, offica		28f. Location City or To	(Streat and Numb wn, State)	ber or Rura	I Route Number,
• Hospitu • Funera • Funera detely fille	29a. Cartifiar 1 Certifying Pl	hysician: To the best of m miner: On the basis of axa and mannar stated	amination and/o	laath occurre or invastigation	ed at tha tir	me, date and place pinion, death occ	ca, and dua to the curred at the time	cause(s) and ma , date and place,	annar as st	tated. the cause(s)
within To the	29b. Signatura and fittle of certifier	4.01		2	29c. Licans			29d. Data signe		Day, Yaar)
		4000			D 4	6478		9.8-	98	
	30. Nama and addrass of person who	completed cause of death	n (itam 23a) (Ty	rpe, Print)						
	Suretu A.	Patrim	0.75	51 Sc	1288×	HSRel	# 307	r. Olin	tomic	786 ob an



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Sept. Dey **Physician** David S. Rittenhouse 4, 1998 5:30 A.M. /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 722 State St. Wicomico Sharptown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F Days Hours Yrs. 214-28-3670 Director 66 Pa. Usual Residence of Decedent the Maryland 10a State 10h County 10c. City. Town or Location "natural", or items 23a or 28a-f show 10d. Inside City Limits 17 Yes 2 □ No Director Wicomico Sharptown 10e. Street and Number 10f. Zlp Code 10g. Citizen of Whet Country? with Md. 21861 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Korean 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status Peges 1 end 2 should be filed within 72 hours efter of ent of Health end Mental Hygiene.
int: If item 27 is marked other than "netural", or item into or other traumatic event, the Mental Calantal III yor other traumatic event, the Mental Calantal 1 ☐ Never Married 2 N Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Textile Operator E.I. DuPont 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be David N. Rittenhouse Myrle Royer 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Shirley Rittenhouse, Wife 722 State St. Sharptown, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 N Burial 2 ☐ Cremation 3 ☐ Removel from State permit. Pege Depertment of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Firemens Cemetery 9-8-98 Sharptown, Md. 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that ceused the shock, or heart failure. List only one cause on each line 700 West St. Laure1, De. 19956
Do not enter the mode of dying, such es cardiec or respiratory arrest, Approximate Interval Betw Onset end Death **Physician** styte punctedic cancel /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner The law requires that the death certificete be executed the buriel-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or InJury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medicai Due to (or as a consequence of) 98 USB Part If. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Dld tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed to should be det Records. by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attanding Physician: director. 25. Wes cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 212 No edicai Certification: To this funeral 27. Manper of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural s efter deeth. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homlcide within 24 hours a
To the Funeral C
completely filled 1 Certifying Phyaiclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Wighung Laurel, DE (9900 ONOCONGE, UD 345 Whya 32. Registrer's Signature State Registrar



					Cert	ificate of	f Death		Reg. No.			301	
Physic	ian	1. Decedent's Name (First, Middle, Las						2. Date of De Month	Day	Year		e e Death	
/Medi		Russell James						Septem	ber 5, 1	998	7:5	5 A.M.	
Exami	ner	4a. Facility Name (If not institution, give Avalon Manox		ama			4b. City, Town, or Hagers		10.000.0	of Death hings	tau		
F		5. Social Security Number 6. So		8. Dale of Bir	_	eta or Eoraian							
Funeral Director		214-09-2161 X	7,1907	ate or Foreign									
Manyland a-f show	tor	Md. Wash	ington	10c. City, T	own or Loca Sm	iths bur	.g			10	10d. Inside City Limits 1 ☐ Yes 2 💢 No		
th with the 23a or 28	Funeral Director	10e. Street and Number 22000 Leitersbu	rg-Smiths	bwrg R	ld.	101. Zip Code 2 1	783		10g. Citizen of V U.S.		ry?		
permit. Pagas 1 and 2 should be filed within 72 hours efter death with the Maryland Depetrment of Heelth and Mental Hygiena. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any Injury or other traumatic event, i'm Modical Examinat must be notified at ADD.	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Kill Yes, Give Year or Dates:			As Decedent of Hispenic Origin? (Specify Yes Yes, specify Cuben, Mexican, Puerto Rican, el   Yes 2 No Specify:			es or No- elc.) 14. Rece - Ame Black, Whi Specify: (			n,	
72 ho	eted	15. Decedent's Ed (Specify only highest grad	ucation	1	6a. Deceder	nt's Usuai Occi	upetion e during most of wo	rkina	16b. Kind of B	usiness/Ind	ustry		
Hygiena. ther than "	Be Completed	Elamantary/Secondary (0-12)	Collaga (1-4or 5	5+)	Wei		e during most of wored)	Kung	Metal	Co.			
d oth	Be	17. Fether's Name (First, Middle, Last)	n / 0				18. Mothar's Nar			ne)			
marks marks	2	Charles Franklin						uise Sm					
h enc		19a. Informant's Name/Relationship (7 Clarabelle Ripple					et and Number or Ru bwrg-Smit					d 217	
1 and 2 Heelth e em 27 is thar trai		20a. Method of Disposition	. Iwiger					Date	20c. Location -		0.		
nent of I		1 Buriai 2 Cremation 3 🗆		11		tion (Neme of atory or other pl	1						
rtant njun		Donation 5 ☐ Other (Specify  21. Signature of Funeral Service Deens	/	Rest			ry Sept.	9,1998	Hagersa	town, 1	ld.		
Depertments imports any Inju		21. Survivie of Furnish Started Opens	<b>X</b>	1		Nama end Add		12525	Bradburi	Ave.		1	
		Pennis x	1	w			eral Home	Smiths	burg. Md.	2178	33		
		23a. art1. Enter the disease, or comp shock, or heart failure. List only of	licelions that caused ona causa on aach lir	the death. I	Do not enler	the mode of dy	/ing, such as cardia	or respiratory a	rrasi,			Batween	
nysician Medical		immediate Cause (Finai		•						1	Onset e	end Death	
caminer		disease or condition rasulting in death)	a	Pre	umon	~~				-	24	دوما	
	ē			Dua to (or as	a conseque	enca of):						T	
Insit	Examiner		D	سم احد		Accio	Lun-			<u> </u>	Lm	مار <i>ا</i> م	
n end lei-tra	Exa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying		Due to (or as	a conseque	enca of):				1			
hysician end the buriel-transit	call	Cause (Disease or injury that initiated events	c	Due to fee to						i			
phy s the	-	resulting in death) Last		Due to (or es	e conseque	inca of):				i			
attanding phy I for use es th	N		d										
d for	icia	Part II. Other eignificant conditions co	ntributing to death by	ut not resultin	o in the und	erlylna ceuse a	iven in Part I	23h Did	tobacco usa co	ntribute to	the cau	ee of death?	
signed by the a I be datached f	Physician/Med		inibating to death be	ot not resultin	ig in the drie	ellying cause g	iveri ii r art i.		Yea 2□ No				
an ed	by F	Hypertennia											
2 should	Completed									ava	ilable pr	osy findings for to of cause	
, - 5	E O							10	Yes 2 No	1 🗆	Yas	2□ No	
this certificate ral director, par	Be	25. Was casa referred to medical					26. Place of Dea	ath (Check only	ona)	1			
en 13	To	examinar? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	nt 2 ER	/Outpatient	3 DOA	ther: 4 19 Nursing H	lome 5 Resi	denca 8 □Oth	ar (Specify	)		
octor: After thi by the funeral		27. Mannar of Death  1 Natural 5 Pending	28a. Date of Injur (Month, Day	ry Year) 28	b. Time of Injury	28c. Inju	ury at ork?	28d. Describe	how Injury occur	red			
oath. or: Af he fu	atic	2 Accident investigation			,,		Yes 2 No						
s after death, I Director: A id in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be datarminad	28e. Place of Inju- building, etc	ury - At home c. (Specify)	, farm, stree	t, factory, office	3		8f. Location (Street end Number or Rural Route Number, City or Town, State)				
within 24 hours aftar death. To the Funeral Director: A completely filled in by the fu	edicai C	29a. Cartifiar (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exam	sician: To the bast of iner: On the basis of end manner sta	examination	dge, death o and/or invas	ccurred at that stigation, in my	tima, data and piaca opinion, death occu	, and due to the rred at the time,	cause(s) and ma data and piace,	anner as sta and due to	ated. the cau	se(s)	
within To th	M	29b. Signature and titia of certifier					nse number		29d. Data signa	d (Month, L	Day, Yes	ar)	
		- tout	mp			01	8019		Safar	7 (5	87		
		30. Name and eddress of person who co	ompieted cause of de	eath (Item 23	a) (Tvoa. Pr	int)							
		Vasant Datta M.D.					21740						

32. Registrar's Signature

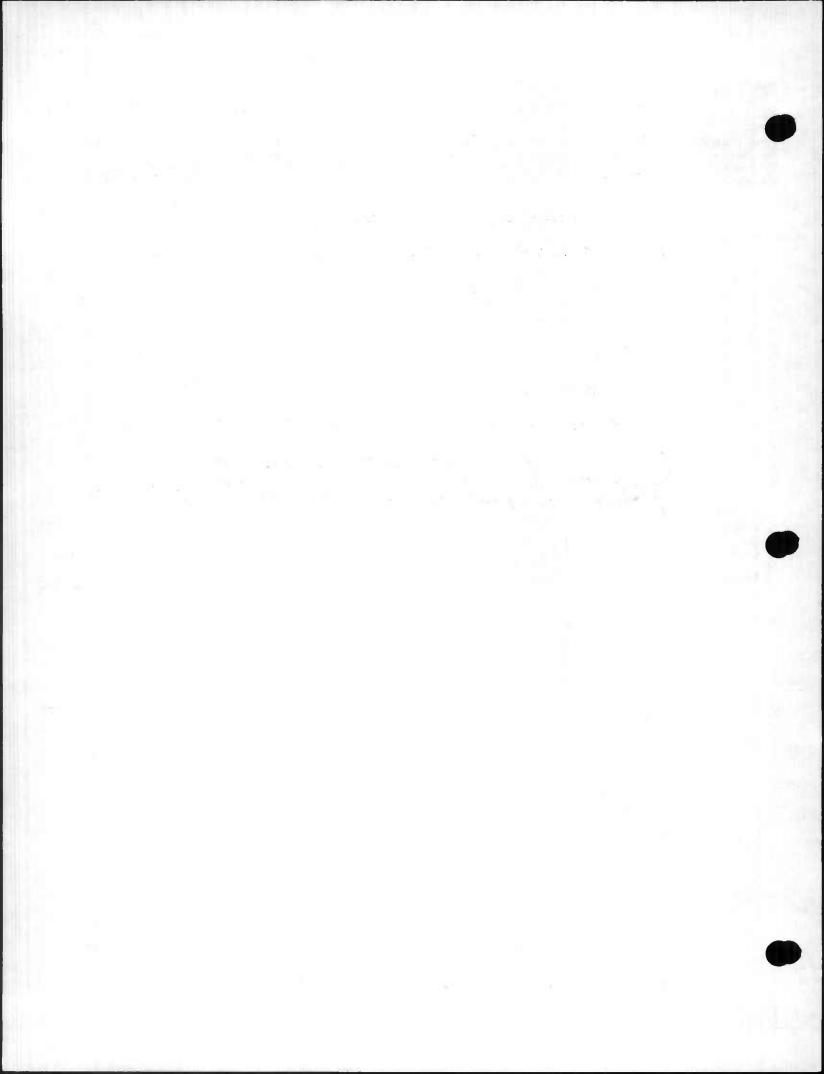
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State

Registrar

31. Date filed (Month, Day, Year) SEP 0 9 1998



State of Maryland / Department of Health and Mental Hygiene

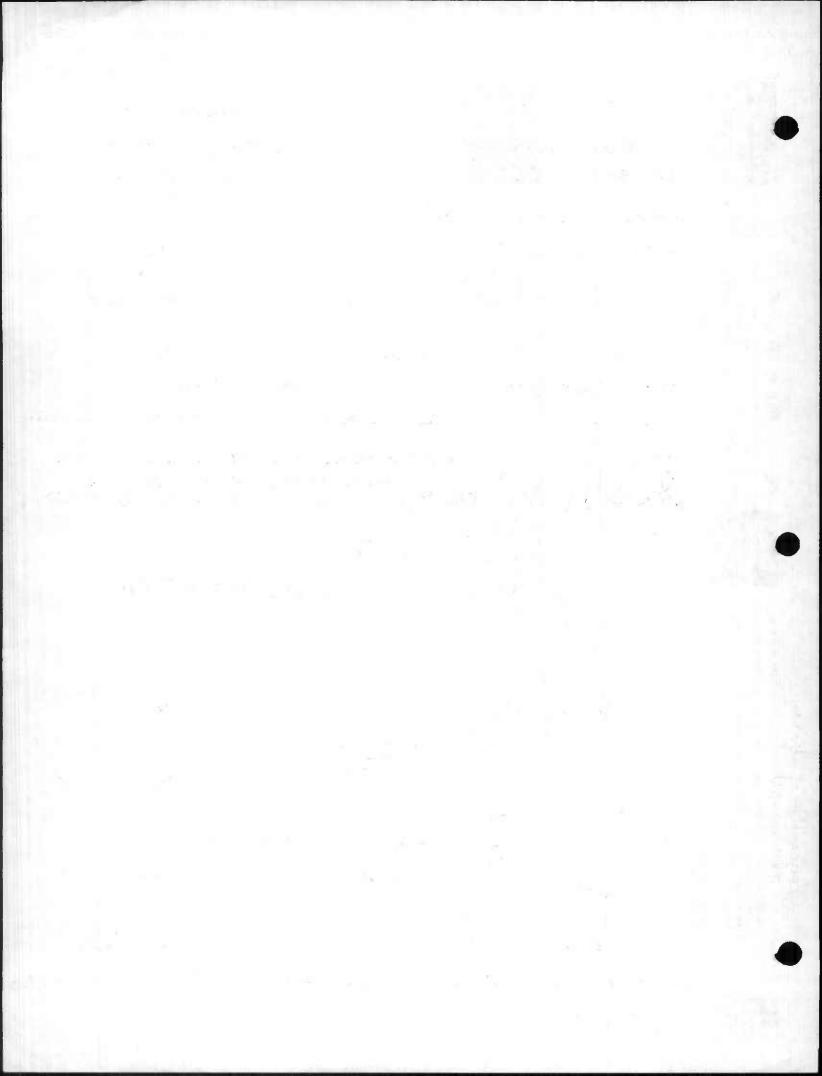
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** 0845 Mary Irene Royce SEPTEMBERS-1998 /Medical 4e. Fecility Neme (If not instifution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Hagerstown Was

| Houser 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | July 28, 1905 Washington County Hospital

5. Sociel Security Number 6. Sex 7. Age (In Washington 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 1□M 2□F Yrs. 93 Director 213-18-9380 Maryland Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f shore Washington Maryland Yes 2□ No Director Hagerstown 10e. Streat end Number 10f. Zip Code 10g. Citizen of Whet Country? 11 W. Baltimore Street 21740 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 72 hours eftar 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Detes: 21215-0020 "natural', or 1 Yes 2 No Specify: ğ Specify: White 3 ☐ Widowed 4 ☐ Divorced be filed within 72 houtal Hygiene.
d other than "natura Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Home 5 Homemaker 7 is marked other traumatic event, Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) . Pages 1 and 2 should be file ment of Haalth end Mental Hy lant: If them 27 is marked oth jury or other traumatic event Myers Charles Frank Myers Minnie May 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 11 W. Baltimore Street Hagerstown, Maryland21740 Doris J. Cass 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) permit. Page Department of Important: If eny Injury or once. Cedar Lawn Memorial Park 9/9/98 Hagerstown, Maryland 21. Signeture of Funerel Servica Licensee Gerald N. Minnich 305 N. Potomac Street Hagerstown, Maryland 21740 Funeral Home 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Onset end Deeth **Physician** /Medical Immediete Ceuse (Finel disease or condition resulting in deeth) Examiner Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest P.O. Box 68760, Physician/Medical Due to (or es e consequenca of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? certificate 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitai: Inpatient 2 ER/Outpetlent 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Aftar Division Attending Neturel Accident 5 Pending Investigation death. ofter death 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital or 24 hours Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hour To the Funer completaly file 29a. Certifier To the 29b. Signature and title of certifier 29d. Dete signed (Month, Dey, Yeer) 29c. License number Tura KU 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) mill St. Hagustown 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State 100 1998 Registrar

**DHMH 16 Rav 6/95** 



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whhlore		by Georgie Pr: 1. Decedent's Name (First, Midd				Certi	ificate	Of I	Jeath		2. Date of De	Reg. No.		3. Time of Deat	
Physician /Medical		James Hoover	ROBERTS								Month August	3, 199	Year 8	4:20 p.	
Examiner		sa. Facility Neme (If not institution Colton Villa	n, give street and	number)		734		4	b. City, To		cation of Death			lngton	
Funeral Director		5. Social Security Number 212-24-6632	6. Sex 1⊠ M 2□ I	7. Age (In yrs. last birthday) If Under 1 Months D					If Under Hours		8. Dete of Bird (Month, Da Nov . 29				
r 28a-f show		Usual Residence of Decedent 10a. State 10b. County Maryland Wa	shington	-	Oc. City, Tow									10d. Inside City Limit	
° % 🗅		10e. Street and Number 50 Summit Aver		10f. Zip								10g. Citizen of	What Cou	ntry?	
at, or items	2	11. Marital Status  1 □ Never Married 2 □ Mar  3 □ Wldowed 4 ☒ Divorcac	12. Wes D Armed 1 ☑ Ye If Yes,					t of Hi	spanic Or n, Mexical Specify:		cify Yes or No Rican, etc.)	- 14. Red	can Indien, etc. ite		
nt, the Medical En		(Specify only higher Elementery/Secondary (0-12)	Colleg	e (1-4or 5+)	16a.	16a. Decedent's Usual Occupation (Give kind of work done during most of world life. DO NOT use retired)					ng	16b. Kind of B			
ever dog	3	7. Father's Name (First, Middle,		18. Mother's Nam-										irants	
is marke eumatic		Chester Robert  19e. Informant's Name/Relations	hip (Type, Print)			Agnes Miller  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stele, Zip Code)  445 Salem Ave. #1, Hagerstown, Md. 21740									
int: If Item 27	2	Becky Moore -  Oa. Method of Disposition  1  Buriai 2  Cremation  4  Donation 5  Other (S	3 □Removal fro		20b. Place of cameter	Dispositi y, cremat		of or place	9)	1	Date 5-98	20c. Location	City or T		
Important: If i any injury or once.	21. Signature of Funeral Service Licansee  22. Name and Address of Facility MINNICH FUNERAL H  415 E. Wilson Blvd., Hagerstown, M  23a. Pent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										HOME				
esician ledical aminer		23a. Pert1. Enter the diseese, or shock, or heart failure. List immediate Cause (Finel disease or condition resulting in death)	only one cause o	each line.	e death. Do n	ai.	lury		, such es	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Deet 2 year	
attending physician and for usa es the burial-transit clary/Medical Examiner	Gause (Disease or injury that initieted events														
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certificate has rector, page 2 Be Comp		Hyperta 5. Was case referred to medical	pnsio	7					00 BI		1 🗆 Y			Yes 2 No	
his certific il director, To Be (		examiner? 1 ☐ Yes 2 No	Hospital:	☐ Inpatient	2□ ER/Out	nationt	3□ DOA	Othe	· .		(Check only o	ne) ence 6 □Oth	or /Cnack	iv)	
ther thunderal	2	7. Menner of Death  1. Natural 5 Pendin 2 Accident investig	g 28a. Dar (Mo	te of Injury onth, Day Ye	28b. T	-	1	Injury Work 1   Y	at ?	11 2		ow injury occur		<i>"</i>	
by tiffe		3 ☐ Suicide 6 ☐ Could r determ	ined 200. Pla		At home, far	14					City or Tow	n, State)		I Route Number,	
Ser Cer	-	a a b	curred at t	t the time, date end plece, and due to the cause(s) end menner es stated.  In my opinion, death occurred at the time, date end placa, and due to the cause(s)											
To the Funeral Director: After the complately filled in by the funeral Medical Certification:		9a. Certifier (Check only one)  1	examiner: On the	ne best of m basis of exa anner steted	aminetion and	Vor invest	tigation, In	my op	nion, dea	th occurre	d at the time, o	late end placa,	and due to	tated. the cause(s)	

30. Name and address of person who completed cause of der th (Item 23e) (Type, Print)

19414 C Leitersburg Pike, Hagerstown

31. Date filed (Month, Day, Year)

SEP 15 1998

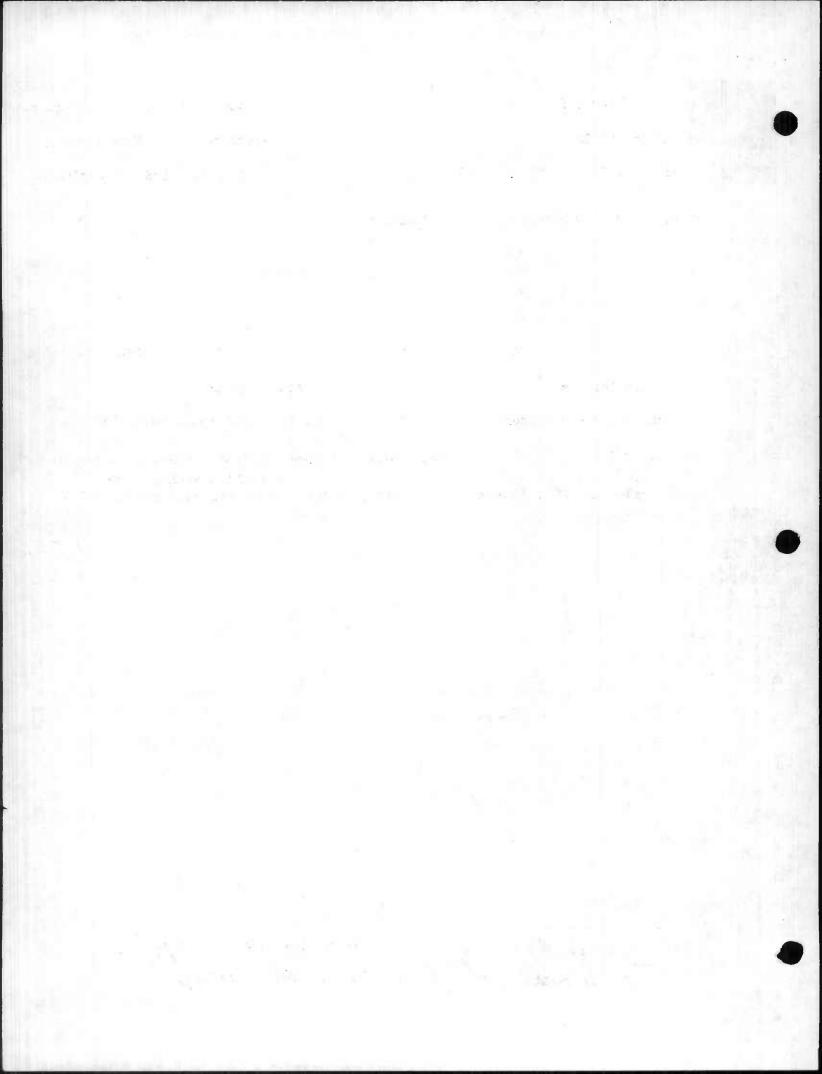
32. Régistrar's Signature

6. Apauls

7/5/98

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State of Maryland / Department of Health and Mental Hygiene

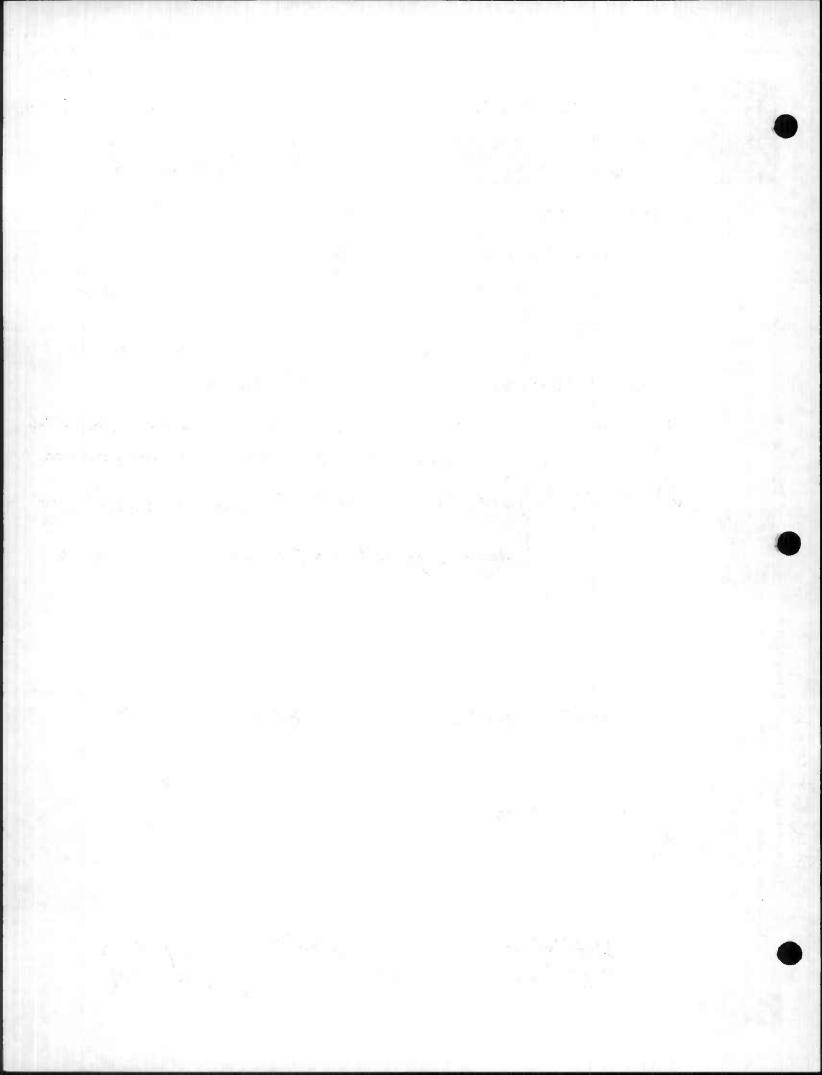
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Month **Physician** 6:26 P.M Franklin Delano Russ, Sr. /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Washington Washington County Hospital Hagerstown Hours Min. 8. Dete of Birth March 7937 If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign **Funeral** 12M 2□ F Deys Months Maryland 218-30-8674 61 Yrs. Director Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Modical Examiner must be notified at Maryland Washington Hagerstown 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21740 USA 606 N. Prospect Street Peges 1 and 2 should be filed within 72 hours efter death nent of Heelth and Mental Hygiene. Institute 21st marked other then "natural", or theme 23 mry or other traumatic event, the Jick Estimation. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ②Yes 2 □ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married Maryland 21215-0020 **Black** 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorcad Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) truck driver Sears - Roebuck 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Eva Williams William McKinley Russ 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Hagerstown, Maryland 21740 Wife 606 N. Prospect Street Hilda Russ Baltimore. 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State Depertment Inportant: If any Injury or 9/4/98 Hagerstown, Maryland Rose Hill Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Servica Licensee 22. Name end Address of Fecility Gerald N. Minnich 305 N. Potomac Street 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

App.

App. 21740 Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner the buriel-trensit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to Immediete cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest and Due to (or es e consequence of): signed by the attending physician be deteched for use es the burie Physician/Medicai Due to (or es e consequenca of): Pert II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? signed by 3 Probably 4 Unknown 1 Tyes 2 No Completed by 24a. Wes en eutopsy performed? 24b. Were autopsy findings eveileble prior to completion of cause of deeth? peen hes 2 No this certificate 1 Yes 1 ☐ Yes 2 ☐ No Attending Physician: director, Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) examiner? Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 2 To the Hospital or Attending Phy within 24 hours efter deeth.

To the Funeral Director: After this completely filled in by the funeral of 27. Menner of Death Date of Injury (Month, Dey Yeer) Medical Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Sulcide 6 Could not be determined 28e. Placa of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) and menner es stated.

Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end pleca, end due to the cause(s) end menner stated. 29a. Certifier 29b. Signature and title of offits 29c. License number 29d. Date signed (Month, Dey, Year) 1266 cause of deeth (Item 23e) (Type, Print) 480 1k2 Thom 31. Dete filed (Month, Dey, Year) 32 Registrer's Signeture State SEP 0 1 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death SEPTEMBER 2, 1998 **Physician** MAURICE JOHN! ROLAND 8:30 AM /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner PRINCE GEORGE'S GENERAL HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign **Funeral** 1₩ M 2□ F 579-22-9972 Yrs. JUNE 22, 1910 Director MARYLAND Usual Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Ineide City Limits "naturel", or items 23s or 28s-f show notch Experies must be notified at Director 1 Yes 2XXNo MARYLAND CHARLES NEWBURG 10e. Street end Numbe 10f. Zip Code 10g. Citizen of Whet Country? 16870 ROCK POINT ROAD 20664 U.S.A. by Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 N No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No 3 N Widowed 4 Divorced Specify: WHITE Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) **FARMER AGRICULTURF** 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) . Pages 1 and 2 should be fill ment of Health end Mental Hy lant: If Item 27 is marked oth jury or other traumatic event GEORGE MILTON ROLAND ROSA EDITH RAUM 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MICHAEL OLDS/GRANDSON 142 TAYLOR ROAD, CENTREVILLE, MD 21617 20b. Pleca of Disposition (Neme of cametery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete TRINITY MEMORIAL GARDENS SEPTEMBER 9, 1998 Buriel 2 Cremetion 3 Removel from State **MARYLAND** permit. Page Department of Important: If any Injury or 4 □ Donetion 5 □ Other (Specify) THE HUNII FUNERAL HOME, INC., POST OFFICE BOX 156, WALDORF, MARYLAND 20604-0156 OOHN P. KNISLEYS M01164 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical MULTIPLE TRAUMATIC INJURIES WEEKS Examiner Physician/Medical Examiner ESPIPATORY FAILURE
Due to (or es e consequence of): WEEKS Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest MULTIPLE FACIAL FRACTURES

Due to (or es e consequence of): WEEKS the CLOSED HEAD INJURY Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the ceuse of death? 1 Yes 2 No 3 Probably 4 Onknown LUNG CARCINOMA WITH METASTASIS by 24b. Were eutopsy findings evaileble prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical Certification: To Be 28. Piece of Deeth (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify)

The lew requires that the death certificete be executed Box 68760. P.O. Division of Vital Records, or Attending Physician: s efter death. I Director: Af within 24 hours e

this

filled in by

Medical

death with the Maryland

filed within 72 hours efter

Baltimore, Maryland 21215-0020

28e. Dete of Injury (Month, Dey Yeer) 28c. Injury et Work? 5 Pending investigation DRIVER 8-04-98 1 Yes 2 No 6 Could not be determined 3 Suicide 4 Homicide

27. Menner of Death 28d. Describe how injury occurred IN AN ACCIDENT 1 Neturel 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) STREET

1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signeture end title of certifier 29c. License number

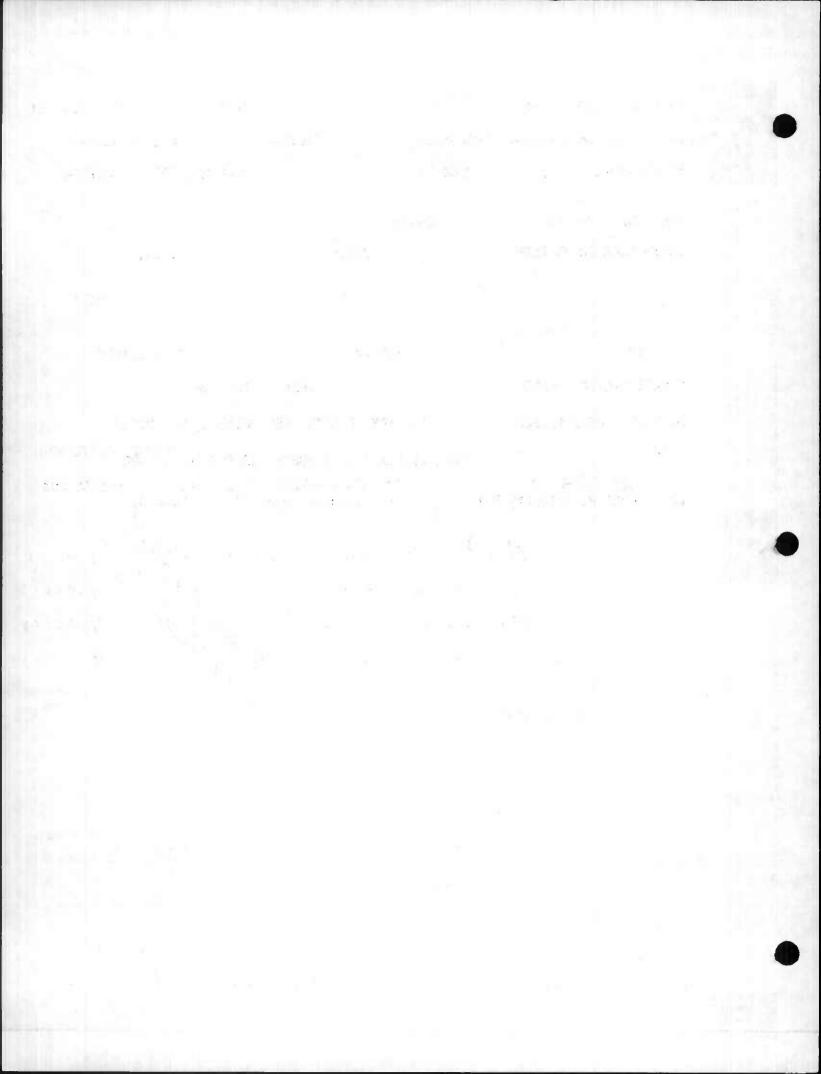
29d. Date signed (Month, Dey, Year) 9-02-98 capera MD 00023927

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

1998

9470 ANNAPOLIS RO. # 307 LANHAM MD. 20706 CASIBANG, MD.

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Day Month **Physician** SALKELD 22:55 August 27, 1998 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ATLANTIC GENERAL HOSPITAL WORCESTER If Undar 1 Yaar 8. Date of Birth (Month, Dey, Year) Birthplaca (Stata or Foraign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours Min 1 M 28 F Yrs. 212-64-3368 Director 88 December 12,1909 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 Yas ZX No Maryland Worcester Berlin Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Meadow Lane - Gull Creek 21811 USA Fages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.

If the AZ I a marked other than "natural", or Items 23, market other than "natural", or market and a strong property of the Azida Example manny on other traumatic event, the Medical Example manny. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yas, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2₺ No Specify: White Ď 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) Etementary/Secondary (0-12) Cotlege (1-4or 5+) Domestic 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Harry Clayton Taylor Lottie Jane Allen 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Marsha L. Renfrow/Daughter #6 Wanman Lake, Selbyville, DE 19975 20b. Place of Disposition (Name of cemetery, cremetory or other place) Deta 20c. Location - City or Town, State important: if its any injury or oth 6008 1 Burial 2 Cremation, 3 Remove from State 9/1/98 Washington, DC Cedar Hill Cemetery 4 Donetion 5 Other (Specify) 22. Name and Address of Facility
Holloway Funeral Home 21. Signature of Funeral Service Licensee 501 Snow Hill Rd., Salisbury, MD 21804

Enter the disease, of complications that caused the Math. Do not enter the mode of dying, such as cardiac or respiratory errest,

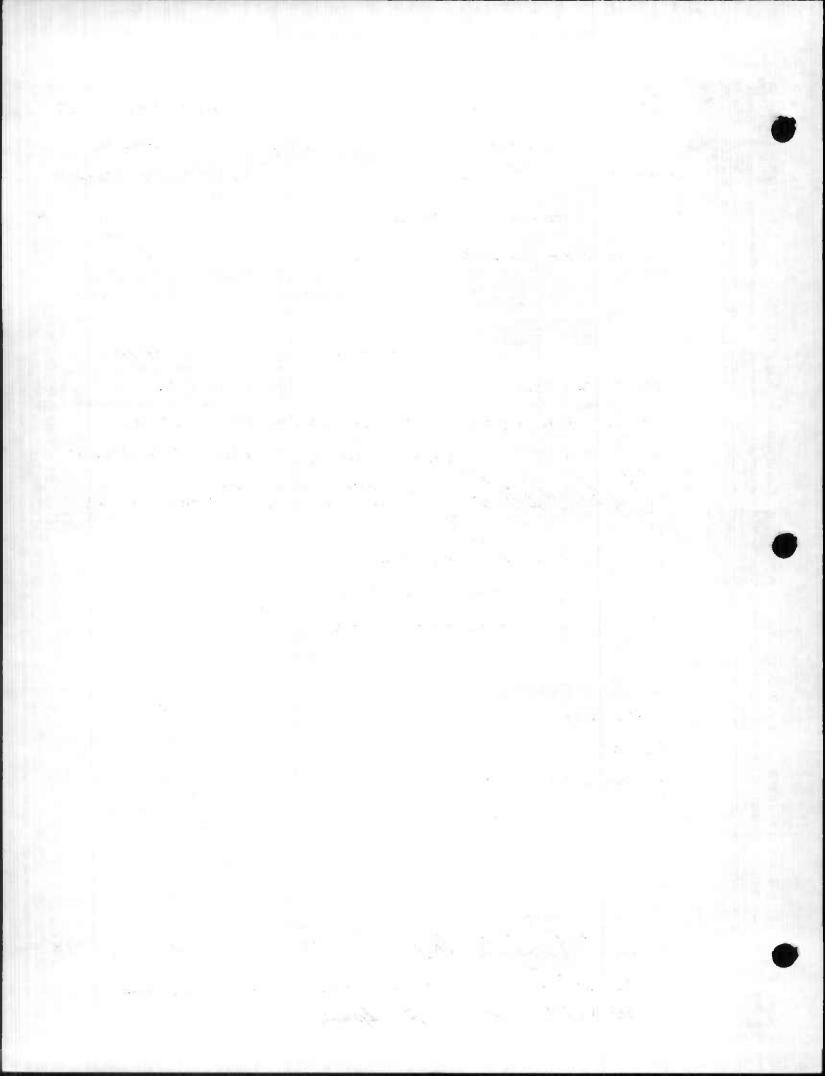
Ack, or heart feilure. List only one cause on each lipe. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE Examiner Due to (or as a consequence of) Examiner Pneumonia & aspiration The law requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disease or Injury that initiated avents resulting In deeth) Last Due to (or as a consequence of): Records. P.O. Box 68760. Possible intraabdominal Physiclan/Medical Due to (or as a consequence of) 88 attanding p signed by the a 23b. Did tobacco use contributa to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Pancreatitis g 24b. Were eutopsy findings available prior to completion of cause of death? should 24a. Was en eutopsy Completed UGI hemmorhage s cartificate has b 1 Yes 2√ No 1 ☐ Yes 2 ☐ No congestive heart failure Division of Vital Physicien: diractor, Be 25. Was cese referred to medicel axeminer? 26. Piece of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this funeral 28d. Describe how injury occurred 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Certification: After 5 Pending Investigation or Attending 1 XNaturel 1 Yes 2 No death. after death.

Director: A
d in by tha for 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Direc complataly filled in br Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dev. Year) 29b. Signature end title of certified 29c. License number D47117 ence und eddress of person who completed cause of deeth (Item 23a) (Type, Print) Jean Rinaldo M.D. 124 N. Main St. Berlin, MD 21811 410-641-2600 32. Registrar's Signeture 31. Date filed (Month, Day, Year)

Registrar

SEP 0 1 1998



State of Maryland / Department of Health and Mental Hygiene

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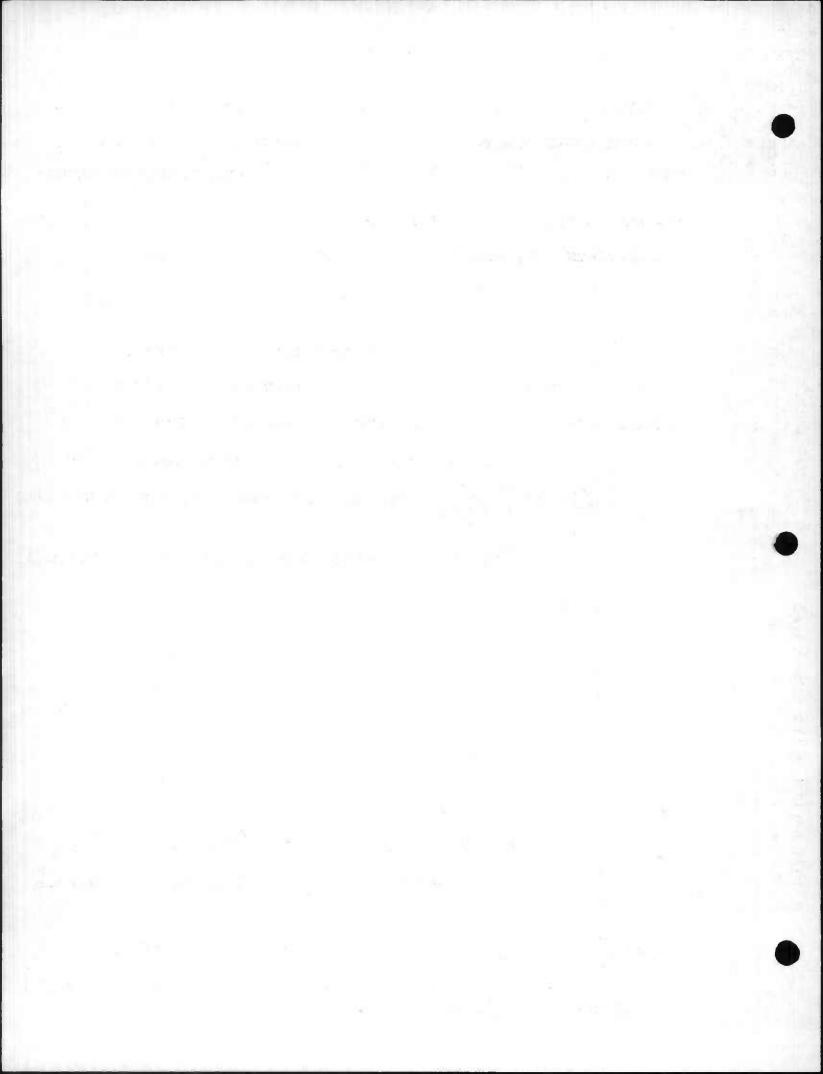
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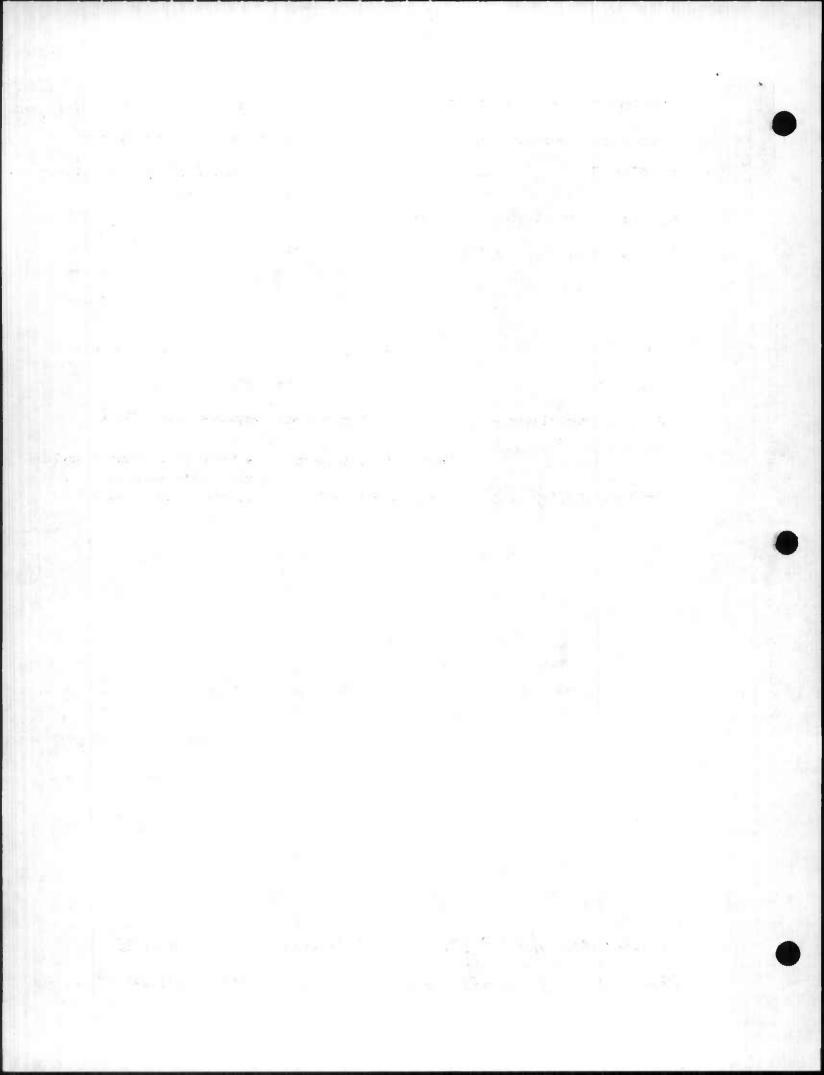
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		Maryen 30 Name and address of marges	J way	ath (Item 22-) (T		)2836	72		9-7-	Qy	
		30. Name end eddress of person who can be seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the seen as the	5 S HAP	1. 368	MILC.	STRBI	BT /	HACIBR	STOWA	ما د	1021740
Sta Regist	-	31. Dete filed (Month, Dey, Year) SEP 0 8	32. Registre	rs Signeture	19. Ap.	ocks					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Mary Margaret SOWERS September 5, 1998 8:30 a.m. 4e. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Colton Villa Nursing Home Washington Hagerstown If Under 1 Yeer | If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 M 2 F Months Hours Indiana 90 Yrs. 306-14-8404 Oct.7,1907 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Hagerstown 1 Yes 2 No Washington 10f. Zip Code 10g. Citizen of What Country? 11403 Stonecroft Ct., Apt. 307A 21742 USA 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Black, White, etc. 1⊠ Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5± church minister 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Nellie Denniston Winfield Scott Sowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Stanley Sowers - nephew Rt.3, Box 442A, Charlestown, W. Va. 25414 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 132 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 9-11-98 Rochester, Indiana Odd Fellows Cemetery 21. Signature of Euneral Service Licensee 22, Name end Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervei Between Onset end Deeth ATHEROSCLEROTIC CARDIO VASCULAR 24-lay 2 Years CEREBROVASUULIAR. ACCIDENT Due to (or as a consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 □ Unknown 1 Yes 2 No nare 24b. Were autopsy findings eveilable prior to completion of ceuse of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one)

**Physician** /Medical **Examiner** Examiner

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The law requires that the death certificate be executed

Box 68760.

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or Attending Physician:

**Physician** 

/Medical

**Examiner** 

10a, State

Maryland

10e. Street and Number

Funeral

Director

ms 23a or 28a-f show

'natural', or Items 23a or

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permit. Peges 1 and 2 should be file Depertment of Health and Mantal Hy Important: If Item 27 is marked oth any Injury or other traumatic event socies.

the Medical Examiner

Director

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Completed

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death

filed within 72 hours efter

altimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

Immediate Cause (Final

disease or condition resulting in death)

Physician/Medical by

Completed

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Certification:

Medical

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical 1 Yes 2 No

27. Manner of Death 1 Natural
2 Accident 5 Pending investigation

29b. Signature end title of certifier

3 Suicide 4 Homicide

6 Could not be determined

28a. Date of Injury (Month, Dey Year) NIA 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury NIA

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury et Work?

NIA 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

NUA 28f. Location (Street and Number or Rural Route Number, City or Town, State)

17 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the ceuse(s) and menner es steted.
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier

29c. License number 28365 29d. Date signed (Month, Dey, Year)

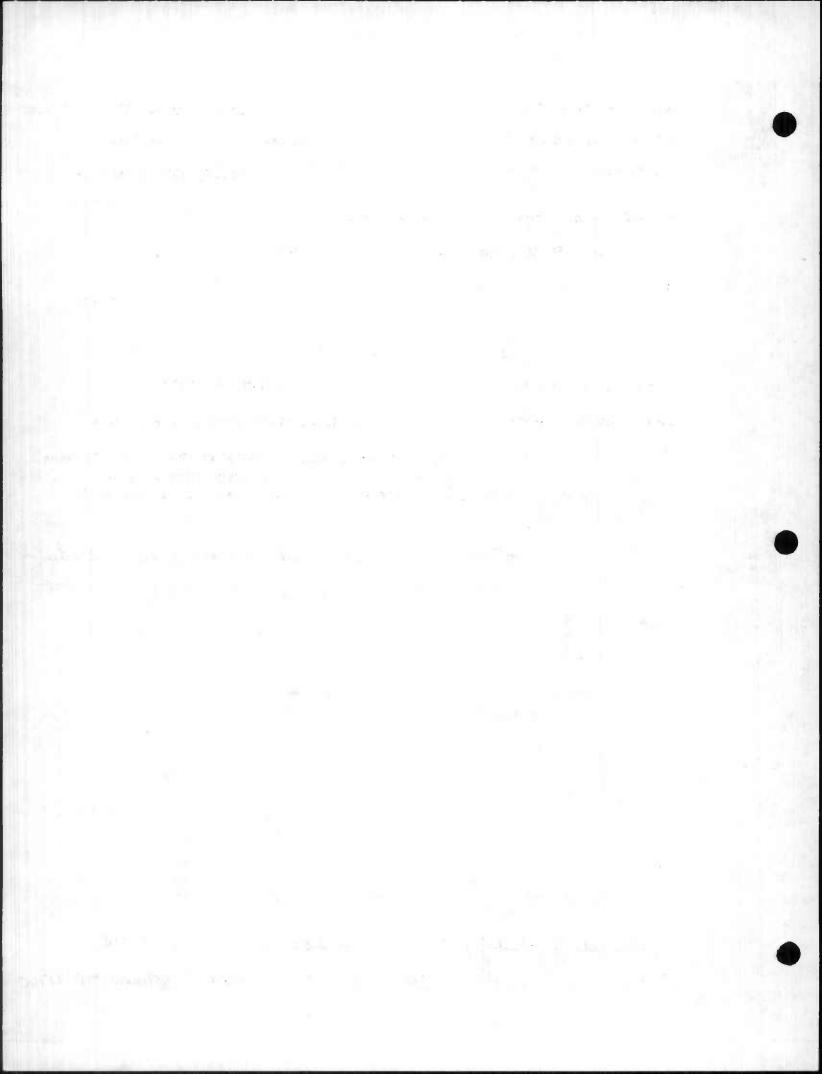
completed cause of death (Item 23a) (Type, Print)

MILL STREET HARLE RETOWN MD 21740 AFI. 368

State Registrar

31. Date filed (Month, Day, Yeer) SEP 0.8

32. Registrar's Signature

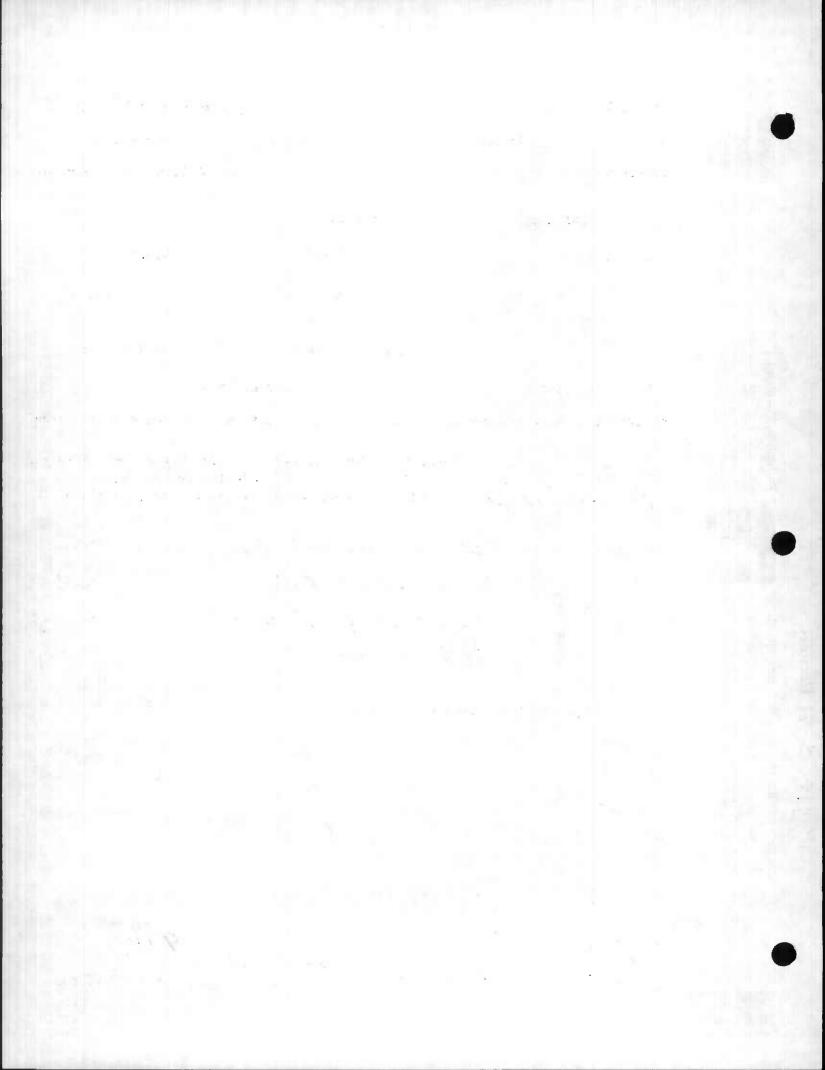


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) **Physician** Scatember Basil Vernon SKAGGS /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Hagerstown W
If Under 24 Hrs. 8. Data of Birth
(Month, Day, Year) Washington County Hospital Washington If Under 1 Yaar 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10XM 2□ F Months Days Yrs. 79 Director 236-24-9621 Oct. 4 1918 West Virginia Usual Residence of Decedent with the Marylend 10a State 10b. County 10c. City. Town or Location 10d. inside City Limits rai", or items 23a or 28a-f show Examiner must be notified at Yes 2□No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Walnut Towers U.S.A. 21740 2 should be filed within 72 hours efter death end Mental Hygiene. Is marked other than "natural", or items 23 aumstic event, the Modest Exemples in the modest. Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: White py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Aluminum Shed Factory Worker 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) John Wesley Skaggs Lula A. Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 end 2 sh Depertment of Health end Important: if Itam 27 is m any Injury or other traum page. 80 162 S. Potomac Street Hagerstown, Maryland 21740 Alberta Champagne - Daughter 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Memorial Park 9/5/98 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heer feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Examiner physician end the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting In daath) Last The law requires that the death certificete be Physician/Medical esn 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Mration 1 Yes 2 No 3 Probably 4 Unknown precurato by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 Yes 2 No or Attending Physician: funeral director, Be 25. Wes case referred to medical examiner? 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 2 Impatient 2 □ ER/Outpatient 3 □ DOA Certification: To this 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 5 Pending 1 ☐ Yes 2 ☐ No the Funeral Director: A Investigation 2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edica 1 🗲 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Within 2 To the Complet 29b. Signapare and title of certifie 29c. Licensa number 29d. Date signed (Month, Dey, Year) D41131 on -7 -338 mill 84 30. Name and address of person who completed gause of deeth (Item 23e) (Type, Print) Copports ERR Magers Jown 32. Registrer's Signature State SEP 08 1998 Registrar

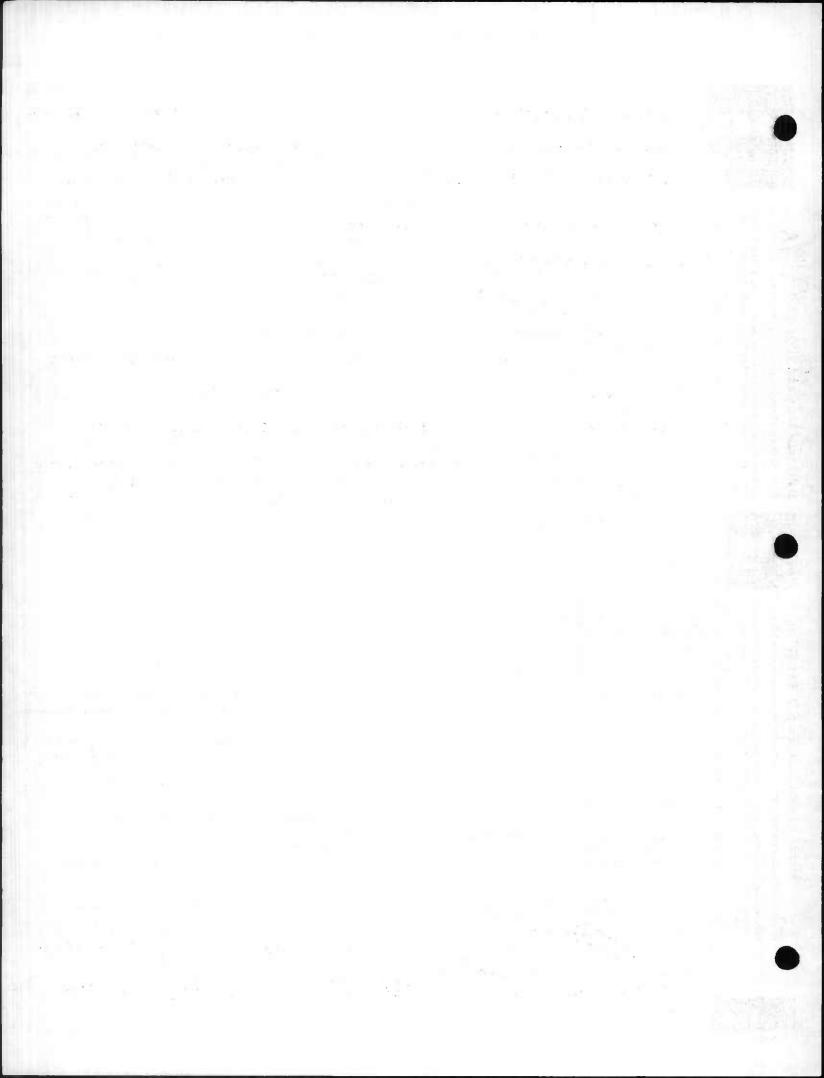
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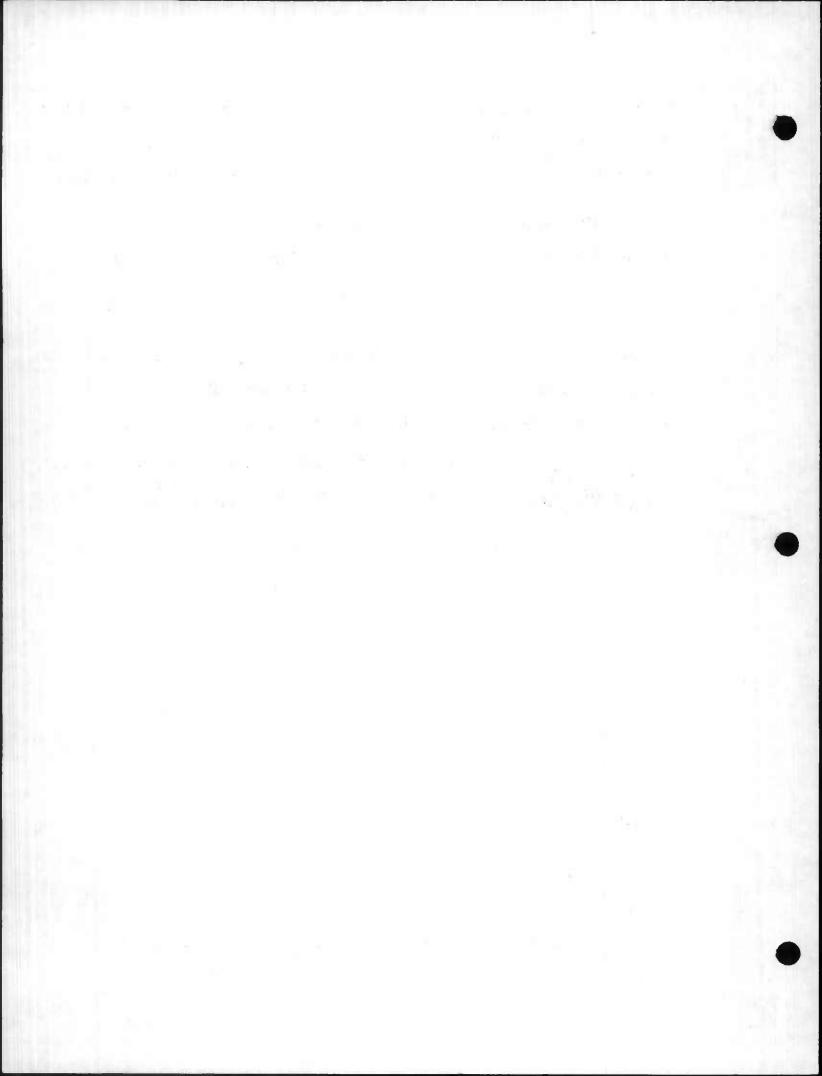


State of Maryland / Department of Health and Mental Hygiene

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/Medical Examiner	_	Lillian Sylv:  4a. Facility Nama (If not institution)					4b. City, Town, or L	Aug. 31	1998 4c. County		A · M
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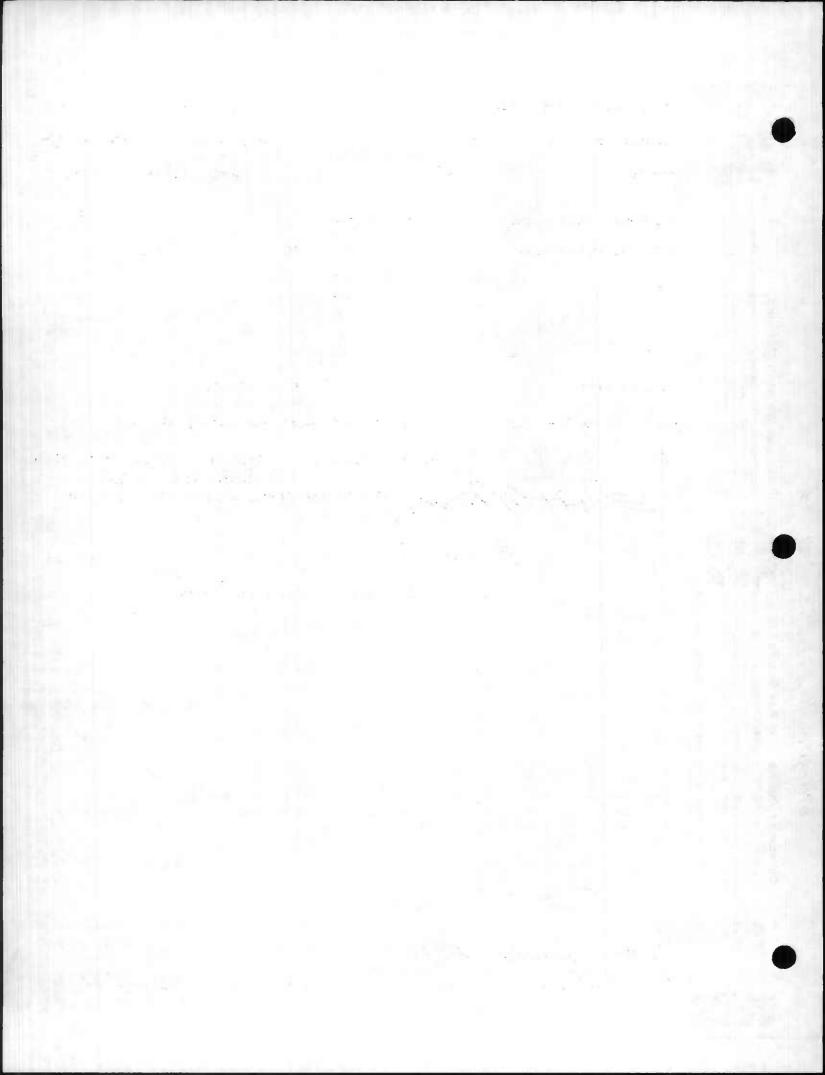


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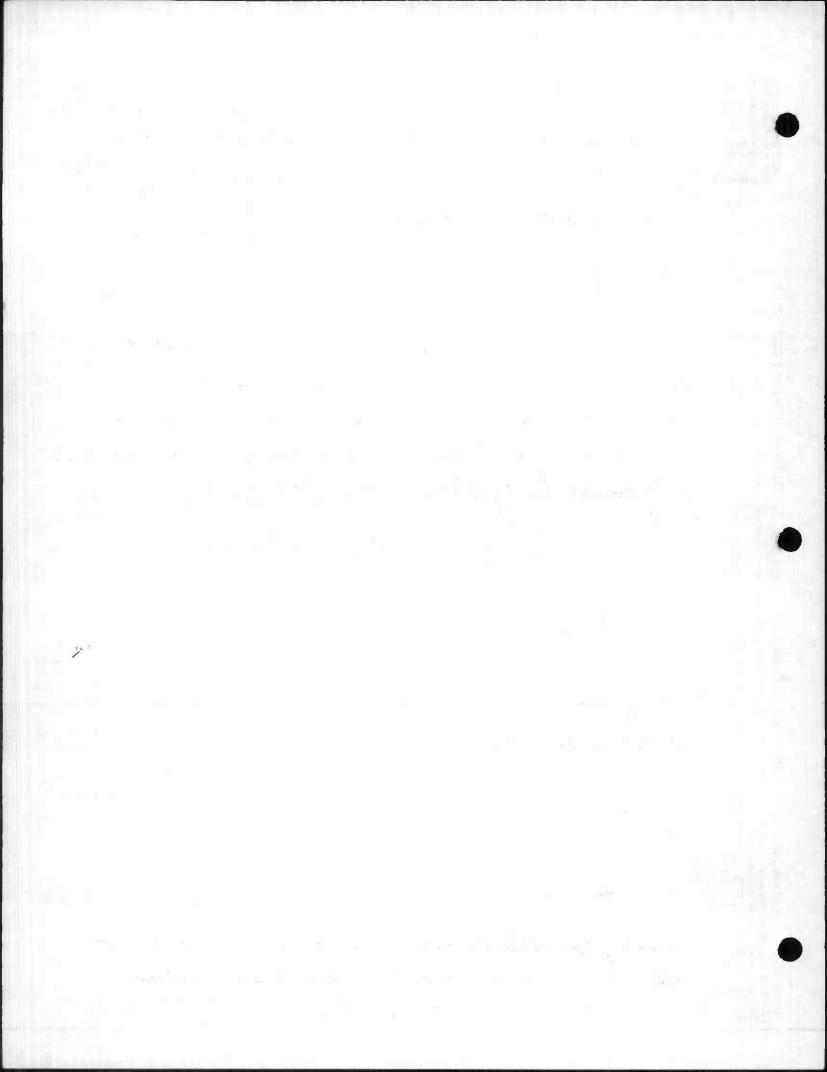
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Carly Left Inscount in v VI SAME IN LIE LES INTE INVESTIGATION TO THE [4] A. M. Aleman, Man. M. A. May, A. M. M. Martin, Phys. B 50 (1997) 11, 127 (1997). 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 3. Tima of Deeth 2. Dete of Deeth Month Day **Physician** CARRIE LEE SAUNDERS 1998 /Medical 4b. City, Town, or Location of Deeth 4e. Facility Nama (If not institution, giva street end number) 4c. County of Deeth Examiner GENESIS ELDERCARE; CHESAPEAKE WOODS CAMBRIDGE DORCHESTER 8. Data of Birth (Month, Dey, Year) JUNE 9, 1899 5. Sociel Security Number 6 Sax 7. Age (in yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1□ M 21XF Months Days Hours MARYLAND 99 Director 215-03-2581 Usual Rasidanca of Dacadant with the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d, Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 XYas 2 No Director DORCHESTER MARYLAND SECRETARY 10e Street and Number 10f. Zip Code 10g. Citizan of Whet Country? 126 SECOND STREET 21664 USA death v Funeral Was Decedent of Hispenic Orlgln? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status Was Dacadant Evar in U.S. Armed Forcas? 14. Race - Amarlcan Indian, Black, Whita, atc. filed within 72 hours after 1 ☐ Yas 2 XNo If Yas, Giva Year or Datas: 1 Navar Married 2 Marriad Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: WHITE þ 3 X Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacadent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiene. Elemantary/Sacondary (0-12) Collage (1-4or 5+) MANUFACTURING permit. Pages 1 and 2 should be filled with Department of Health and Mentel hygien important: If them 27 is marked other the any injury or other traumatic event many SEAMSTRESS 6 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middla, Maldan Sumama) Be JOHN BRADLEY ELIZABETH HURLOCK 0 19a, Informent's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) GERALD SAUNDERS/GRANDSON P. O. BOX 53, SECRETARY, MARYLAND 21664 20b. Place of Disposition (Nama of 20a. Mathod of Disposition Data 20c. Location - City or Town, Steta cematary, crematory or other plece) 1 Burial 2 □ Cramation 3 □ Ramoval from Stata EAST NEW MARKET CEMETERY 9/11/98 EAST NEW MARKET, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility ZELLER FUNERAL HOME, P. O. BOX 207, 106 MAIN STREET, EAST NEW MARKET, MD 21631 inplications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory arrest, one cause of each line. 6a. Part / Entar tha disaasa, or co Approximate Interval Batween Onsat and Deeth Physician FAILURE Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner requires that the death certificate be executed Sequantially list conditions, if eny, leading to immadiata cause. Enter Undarlying Causa (Disease or Injury thet initietad evants rasulting in daath) Lest Dua to (or as a consequence of): ğ the burial-tra-Box 68760, physiclan Physician/Medical Dua to (or as e consequence of) for u P.O. Part II. Other signifficant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 25No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? Broker Olcer page 2 certificate hes The 1 Yas 22 No 1 Yas 2 ONo Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to madical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yas 2 →No 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 4 Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Dascribe how Injury occurred Certification: 1 Natural 5 Pending investigation 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At home, farm, streat, fectory, offica building, etc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 6 4 D Homicide Ecartifying Physician: To tha best of my knowledge, deeth occurred at the time, date and place, and due to the causa(s) and menner as stated.

Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier completely (Check only 29b. Signetura and titla of cartifier 29d. Deta signed (Month, Day, Yaar) 29c. Licanse number 30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print) Adden mo 302 (8/12) Achnel 31. Data filad (Month, Day, Year) 32. Registrar's Signature 1998 Registrar



2881 3. Time of Death 7:22

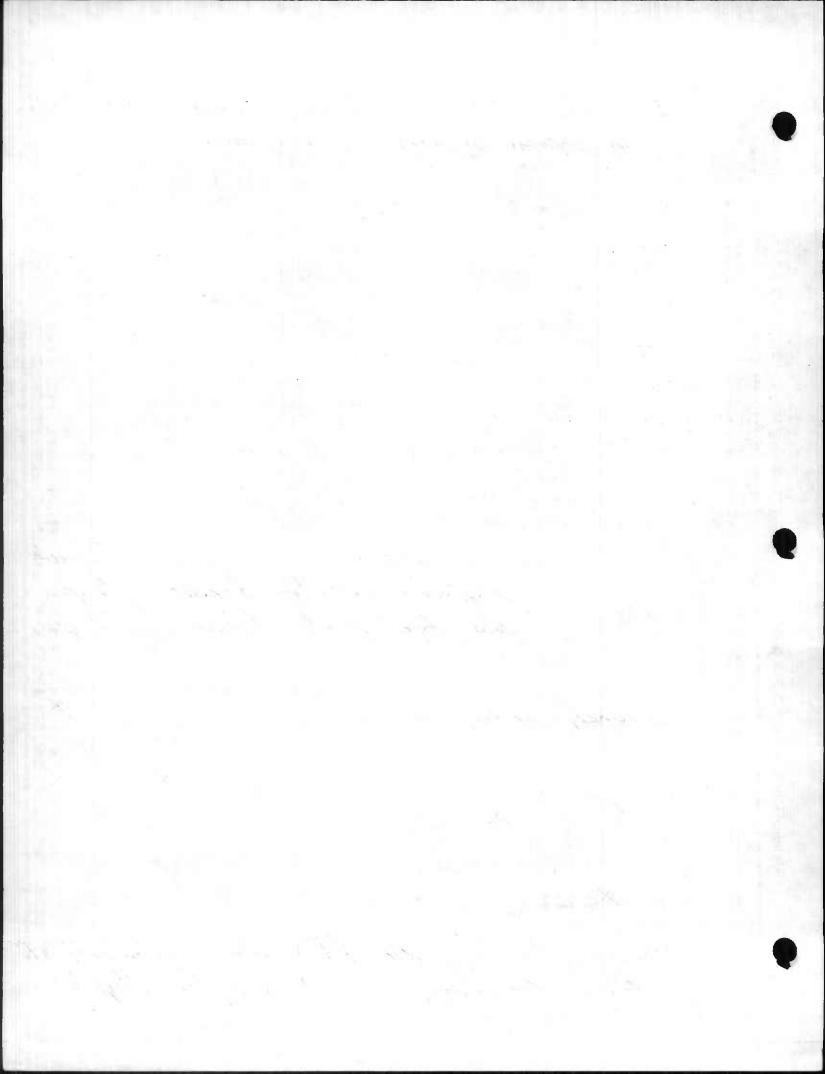
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ian	1. Decedent's Nama (F	irst, Middle, Las		DETH		//	,	. ,		Pata of Death	Day,	Xeer	3. Time of Death
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ner	4a Fecility Name (# no	t institution, give	e street and numb	ner) / /	1,	,	4	b. City Legun	Logano	n or Death	4c. County	of Death	
	5 Social Security Num	ber 6. S	Mans 1	Age (th yrs. )	last hirthday	If Under 1	Year	If Under 24	ten H	The second second	+	0 Birthol	aca (Stata or Foraign
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٠.	Usual Residence of De											WEO!	VINOINIA
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Funeral Director			OIN	NEA	INITETO								1 □ Yas 2/XNo
5	ROUTE 03		206			10f. Zip C	430			10	g. Citizen of		try?
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Š	11. Marital Status 1 Never Married	2D Married	12. Was Deced	es?	5. 13.	f Yas, specify	y Cubai	spanic Origin n, Maxican, P	uarto Ricar	n, atc.)		ck, Whita, a	atc.
Š	3 X Widowed 4 E		1 Tes 2 If Yes, Give Year or Date			1□ Yas 2	No No	Specify:			Specif	v: WH	ITE
	15	. Decedent's Ed	lucation		16a. Dece	dent's Usual	Occupa	ntion		10	6b. Kind of B	usiness/Ind	lustry
Be Completed		only highest gra	de completed) College (1-4	or 5+)	(Giva	NOT use	dona d retired)	luring most of	working				
5	Elementary/Seconds UNKNOWN				HON	MEMAKE	R				HOME		
3	17. Father's Name (Fin								Nama (Fir.		aiden Suman	na)	
-													
	19a. Informant's Name LEON R. U			IM				nd Number o					
	20a. Method of Disposi		, unst			Sition (Nama		BOX 45	08, KI		Oc. Location		
	1 X Burial 2 C 4 Conation 5	remation 3 🗆			emetery, crer	natory or oth	ar place	RY GAF					BURG, WV
H	21. Signature of Funer	al Service Licen	see		22	. Nama and							
	poar	us (	hust	ail		WELAT	NI.	STRIC	PER CO	).,INC		05444	
	23a. Part1. Enter the c shock, or heart fa	disease, or comp	olications that cau	sed the death	. Do not ent	ar tha moda	of dying	, such as car	diac or ras	piratory arras	st, WV	25414	Approximata Interval Between
					_							2	Onset and Death
	Immediate Cause (Findisease or condition	al			Sel	25.30							Lweels
	resulting in death)			Due to (or	r as a siseo	juence of):		1		/		1.5	_
			b. pc	. she	a (	val	CL	-lar	d.	real	c	- 2	rear
	Sequentially list condit if any, leading to imme cause. Enter Underlyin Cause (Disease or inju	ions, diata		Due to (or	r as e consec	uence of):		/	/			-	7
	cause. Enter Underlying Cause (Disease or injustrat initiated events)	ng ry	c. en	0 5	tore	10	ne	(	d.se	ALL			/cals
edical Examiner	resulting in death) Last			Due to (or	a conseq	uenca oi):							
			d										
	Part II. Other significan	nt conditions ~	ontributing to deel	th but not resu	Ilting in the re	nderlying cau	ISA DİVA	en in Part I		23b. Did toh	BCCO HEE CO	ntribute to	the cause of death?
Ly rayerolation			/				an Since				2 □ No	3 □ Prot	"
	Coro	12/4	arte	4	dire	ace			_				
				-24						24a. Was an	autopsy ed?	ava	ere autopsy findings allabla prior to
							_		_	politici		COL	mpletion of causa death?
										1 🗆 Yas	2 No	10	Yas 200 No
	25. Was case referred	to medical						26. Place of	Death (Ch	eck only ona	)		
2	examiner?		Hospital:	nationt 2	ER/Outpatier	t 3□ DOA	Othe	ar.			nca 6 Oth	ar (Specif)	1)
:	27. Manner of Death	Pending	28a. Date of		28b. Tima of Injury	280	c. Injury Work	at ?	28d.	Describe hov	w injury occur	red	
3		investigation				М		ras 2□No					
	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	286. Place of	Injury - At ho , etc. (Specify	ma, farm, str	eel, factory,	office			ocation (Stre City or Town,		ber or Rura	l Route Number,
Certification:	20 0 0 1	/								100			
edical	29a. Certifier 12 (Check only 2	Certifying Phy Medical Exam	rsician: To the be iner: On the basi	is of axaminati	vledge, death ion and/or in	occurred at astigation, in	tha tim n my op	a, data and p sinion, death o	lace, and o occurred at	the time, dat	use(s) and m ta and placa,	annar as st and dua to	ated. tha cause(s)
6	G. (C)		and manne	SUMEO.									
ž	29b. Signature and title	Lef CBORRA		100		29c 1	License	number		20	d. Data signe	d (Month	Day Year)

25. Was case referred to medical			26. Placa of	Death (Check only ona)	
examiner?	Hospital:	2 ER/Outpatient	3□ DOA Other: 4□ Nursi	ng Homa 5 Rasidenca	6 ☐Othar (Specify)
27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how in	jury occurred

30. Name and address of person who comple

cause of death (Item 23a) (Type, Print) 32. Registrar's Signatura dian 31. Data filed (Month, Day, Year) SEP 0 9 1998

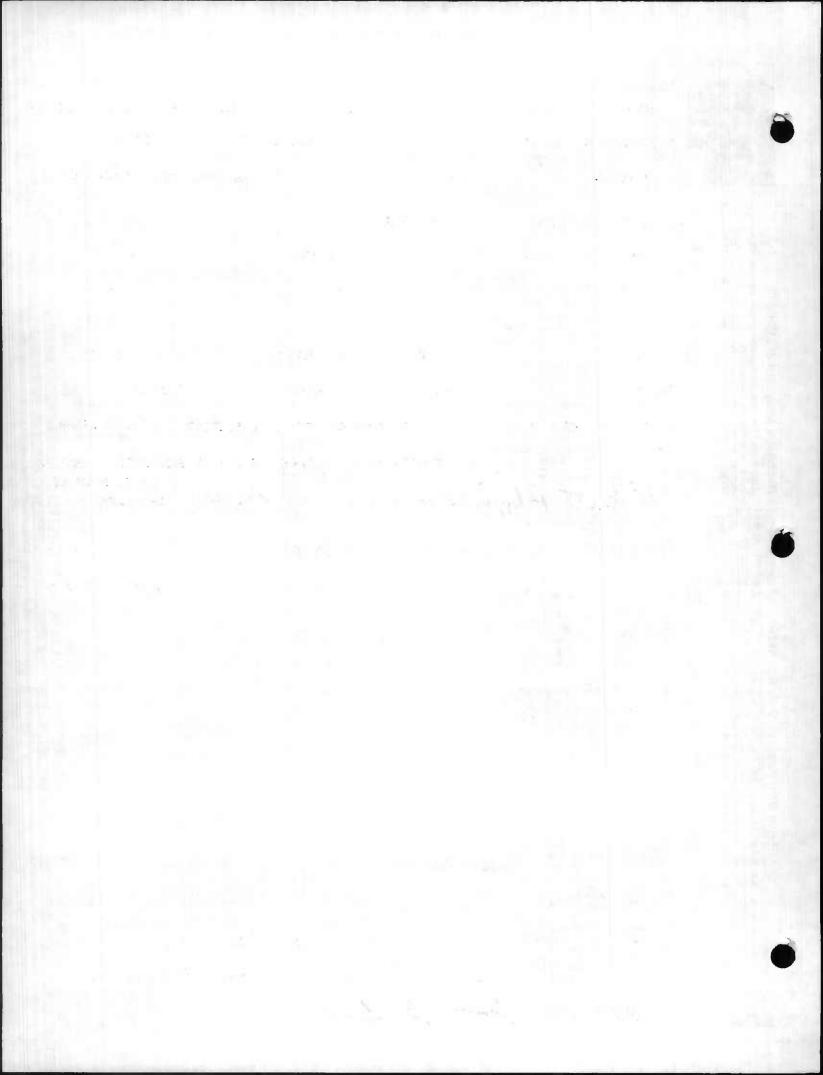
State Registrar



State of Maryland / Department of Health and Mental Hygiene

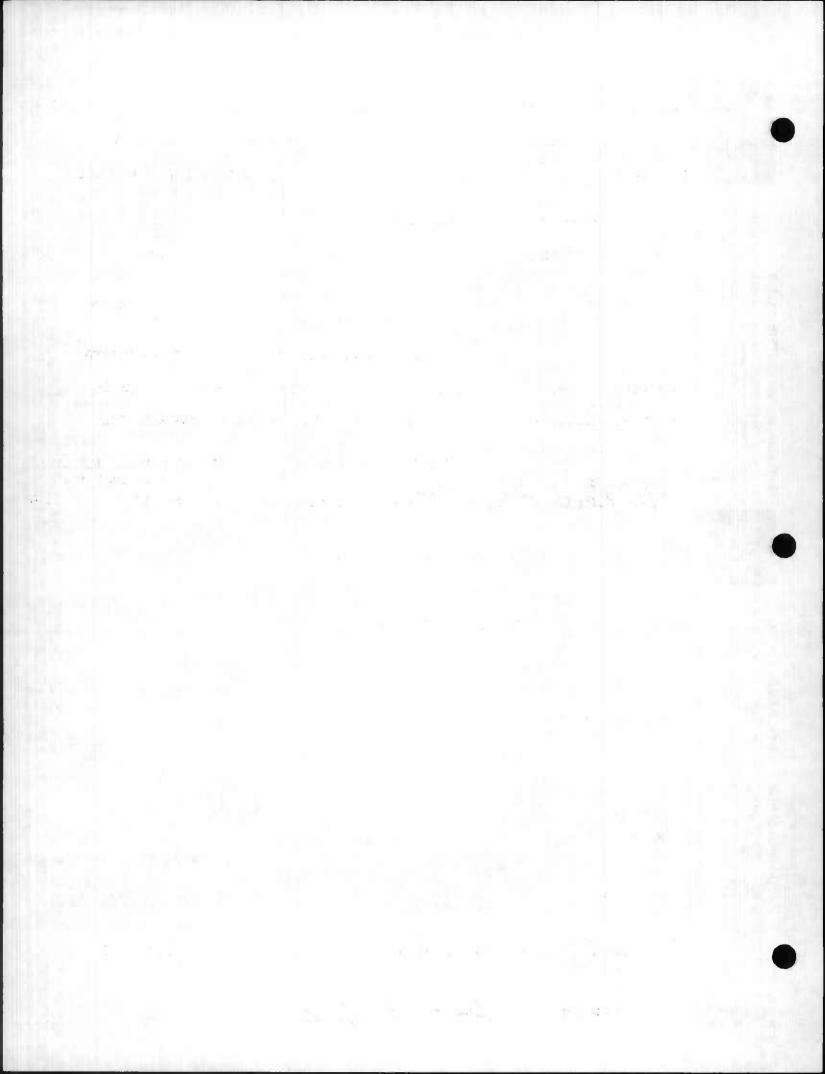
					,,	Certifica	ate of	Death	R	eg. No.	60	50	B
	1		1. Decedent's Name (First, Middle, Last	)					2. Dete of Dee		Yeer	3. Time of	Death
	Physici /Medic		JOHN BE	NJAMIN		WA	LKER		SEPT.			12:31	A.M.
	Examir		4e Fecility Neme (If not institution, give	street end number)				4b. City, Town, or I	Location of Deeth	4c. County	of Deeth		
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	Funeral Director		5. Sociel Security Number 6. Se 11 212-32-0468	ĎM 2□F	(In yrs. last i	Yrs. If Und Month	der 1 Year Deys	Hours Min.	8. Deta of Birth (Month, Day		9. Birthple Counti MARYI	ece (Stete o ry) [.AND	ir Foreign
			Usuel Residence of Decedent						JAN. 10	1733			
	th with the Marylan 23a or 28a-f show	tor	10e. State 10b. County  MARYLAND WICOMIC			wn or Location					10	d. Inside CI 1 ☐ Yes	
	or 284	Director	10e. Street and Number				Zip Code		1	0g. Citizen of V	Vhel Counti	ry?	
	th will		6779 ZION CHU	RCH RD.			2	1804		U.S.	A.		
21215-0020	after dea or items	by Funeral	11. Marital Status  1 Never Merrled 2 Merrled  3 Widowed 4 Divorced	12. Was Decedent E- Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Yeer or Detes:			cedent of pecify Cub	Hispanic Origin? (S ean, Mexican, Puert Spacify:	pecify Yes or No- to Rican, atc.)	Bled	e - Amarica k, White, e : WHIT	tc.	
5-0	72 hours "naturel",	pet	15. Decedent's Edu (Specify only highest grad	cation	16	Sa. Decadent's U	suel Occu	petion during most of wor	rkina	16b. Kind of B	siness/Inde	ustry	0 0 - 11
21	within one one.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	)	life. DO NOT	use retire	od)	All I				
	filed w Hygier ther th	Co	10		P	AINTING	CONT			SELF E		ED	
Maryland	A to b	Be	17. Fether's Neme (First, Middle, Last)					18. Mother's Nan	me (First, Middle,	Maiden Sumen	a)		
7	25 5 8	10	ERNEST C.	9:0	WALKE		/0.	MARIE	-10- to M	HAUGHE		0-4-1	
Ma	C/ 40 - 40		19a. Informent's Neme/Reletionship (T)					t and Number or Ru					
	1 an Haaii m 2		TRUDY C. WALKER -	WIFE	20b. Pleca	of Disposition (*	Vame of	RCH RD.	SALISBURY	20c. Location -	City or Toy	21804 vn. Stete	
non	- L		1 Buriai 2 ☐ Cremetion 3 ☐ F			tery, cremetory o							
Baltimore,	Departman Important: any Injury		4 ☐ Donetion 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens	-	WICOM	ICO MEMO		PARK S	9-8-1998				
Ba	permit. P Departmu Importan any Injur		DW +	00	1							IN ST	
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	Physician /Medical		Immediate Cause (Final	CEN	ITOE	An	IEN	۸۱۸				2 MA	NTHS
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	cuted	Examiner	Sequentially list conditions.			e consequence o		2.2 (30)(3)	, ,,,,,,	- 10 /2.1		211/0	1110
0	e axe		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying								i		
68760,	fficata be axecuted g physician end as the burial-transit	edical	Ceuse (Disease or injury thet Initiated events resulting in deeth) Lest	CD	ue to (or es	e consequence o	of):						
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P.O. Box	eath cart attendin	lan											
Ö	ires that the death car signed by the attendir d be datached for usa	Physician/N	Pert II. Other significant conditions co					iven In Pert I.		obacco use co			
	hat the ad by datac	P.	SPINAL	CORD	IN	FARC	T		1 🗆 Y	es 2 No	3 Prob	ably 4	Unknown
ds,	requires that the death car seen signed by the attendin hould be datached for usa	d by							24e. Was	en eutopsy	24b. Wa	re autopsy	findings
00	been s	Completed							perfor		ave	ileble prior to npietion of cleath?	to
Rec	has has	a m								- 7/			1
a			OF Management and the standard						1 U Y		1 1 1	Yes 2	No
5		o Be	25. Was case referred to medical exeminer?  1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatien	• 0 C C C	Outpatient 3	DOA   OI	her: 4 Nursing H	eth (Check only or		or (Consilie	1	
of	Physic ruthis of seal direction	: To	27. Manner of Deeth	28a. Date of Injury	288	o. Time of	28c. Inju		28d. Describe h			/	
on	th. Afte	tio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury M		ork? ]Yes 2 □ No					
Division of Vital Records,	7 2 2 C	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ HomlcIde determined	28e. Placa of Injur building, etc.		farm, street, fact	lory, office		28f. Location (S City or Tow	treet end Numb n, State)	per or Rural	Route Nun	nber,
_	To the Hospital or Attending is within 24 hours after death.  To the Funeral Director: After compietely filled in by the funer	edicai Ce	(Check only 2 Medical Exami	sician: To the best of ner: On the basis of	examinetion	ige, deeth occurr and/or investigati	ed et the t lon, in my	ime, date end plece oplnion, death occu	e, and due to the curred at the lime, o	ause(s) and mi	anner as sta	ated. the cause(s	s)
	thin 2 the mpiel	Med	one)  29b. Signatura and title of certifier	end menner stet	ed.		29c I lean	se number		29d. Dete signe	d (Month I	Day, Year)	
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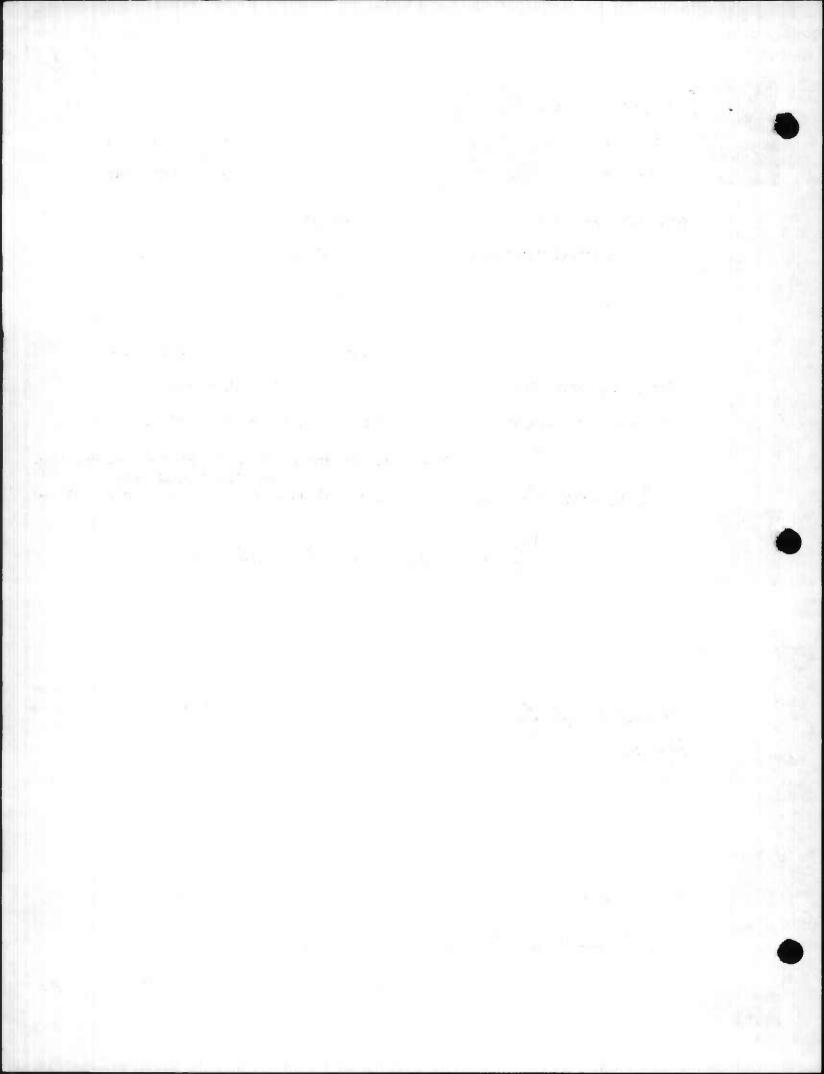
State of Maryland / Department of Health and Mental Hygiene 98 288/9

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Physician /Medical	MILFORD	PAUL		WEB	STER,	JR.			SEPT.		1998	0615 Hs
Examiner	4e Fecility Neme (If not institute		um <i>ber)</i>	1122	DILLIN				cation of Deeth		nty of Death	
LAMITHICI	804 WAVERLY	DRIVE					SALIS	BURY		WICC	OMICO	
THE REAL PROPERTY.	5. Sociel Sacurity Number	6. Sex	7. Age (In vrs	s. lest birthdey)	If Unde	r 1 Year	If Undar		8. Data of Bir	th		pieca (State or Foreig
Funeral Director	219-42-8029	1∭ M 2□ F	54	Yrs.	Months	Deys	Hours	Min.	(Month, De	y, Year)		pleca (State or Foreig ntry)
irector	Usual Residence of Decedent		54					<u> </u>	JAN. 24,	1944_	MARY	LAND
ž **	10a. State 10b. Coun	ity	10c. C	city, Town or Lo	ocation							10d. Inside City Limits
28a-f show notified at rector	MD TITOO	WT GO		TODIID	**							W Yas 2□N
ect ect	MD WICOI 10e. Street end Number	MICO	SE	ALISBUR	1	Code				10a Citizan	of What Cou	Cata
Dir.					101. 24	Code				10g. Citizen		ntry r
rai [	804 WAVERLY					2180				U.S		
by or name 23st of 28st and Example must be notified at by Funeral Director	11. Marital Status	12. Wes De	cedent Ever in Forcas?	U,S. 13.	Was Dace If Yes, spe	dent of F cify Cuba	lispenic Ori an, Mexicar	gin? (Spe 1, Puarto I	cify Yes or No Rican, atc.)	- 14. F	Race - Ameri Bleck, White	
J. J.	1 ☐ Never Married 2 ☑ Ma	If Yes. C	2 No		1 Yes		Specify:				city:	
leted by	3 ☐ Widowed 4 ☐ Divorce	ed Yeer or	Dates:	129		-24-110				Оре	WHI	re
rt, tre Medical i	15. Deced	ent's Education hast grada completed	n	16e. Dece	dent's Usu	al Occup	etion during mos	t of worki	3/2	16b. Kind o	Business/Ir	idustry
pipe	Elementery/Secondery (0-12		(1-4or 5+)	life.	DO NOT	se retire	d)	t or working	'9			
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death 2. Date of Death Month **Physician** George Dewey Watts, Jr. /Medical 4b. City, Town, or Location of Deeth 4a. Facility Nama (If not institution, giva street and number) 4c. County of Deeth Examiner Washington County Hospital Hagerstown Washington Hours Min. June 1, 19 5. Social Sacurity Number 6. Sax 7. Age (In vrs. lest birthday) Birthplaca (State or Foreign Country) **Funeral** 1⊠M 2□ F 70 Yrs. Director 219-20-0754 1928 Maryland Usual Rasidence of Decedant the Maryland 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits show "natural", or items 23s or 28s-f show 1 ☐ Yas 2 K No Director Maryland Washington Hagerstown 10a. Street and Number 10f. Zip Code 10g. Citizan of What Country? 11403 Stonecroft Court 201A 21742 USA Funeral death 12. Was Dacedant Ever in U.S. Armed Forces? 11 Maritai Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexicen, Puarto Rican, atc.) 14 Race - American Indian Bleck, Whita, atc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mantal Hygiena. I ☐ Yas 2 ☒ No If Yas, Give 1 □ Navar Marriad 2 □ Married 0 Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: white by 3 Widowed 4 Divorced Yaar or Datas Be Completed the Medical 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Business/Industry 127 is marked other than "r traumatic event Elamantary/Secondary (0-12) Collega (1-4or 5+) 12 food vendor supervisor 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) George D. Watts, Sr. Elizabeth M. Sprecher 19a. informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If Item 27 is any injury or other trau Deborah Watts - daughter 3311 Cannon Gate Rd. #104, Fairfax, Va. 22031 20b. Place of Disposition (Nama of cematary, cramatory or other plece) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Ramovai from State 4 ☐ Donation 5 ☐ Othar (Specify) 8-31-98 Hagerstown Crematory Hagerstown, Maryland 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signatura of Euneral Sarvice Licensea 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Intervel Batween Onset and Deeth **Physician** /Medical Immediata Cause (Final diseasa or condition rasulting in death) Examiner Dua to (or as a consequence of): Examiner Sequantielly list conditions, if any, leading to immadiate causa. Entar Undarlying Causa (Disaase or Injury thet initieled avants rasulting in daath) Last Dua to (or as a consequance of) Physician/Medicai å Dua to (or as a consaguanca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings evelleble prior to Be Completed 24e. Wes en eutopsy complation of cause of death? certificate Her 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Wes casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: 1 Impatiant Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 10 1 Yas 2 No 2 ER/Outpatient 3 DOA ō 芸芸 27. Menner of Deeth Certification: 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? Affer Division Attending 5 Panding invastigation 1 ANatural 1 ☐ Yas 2 ☐ No 2 Accident siter desti 6 Could not be 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Piaca of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 ☐ Homicide 8 To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowladga, death occurred et the time, dete end plece, end due to the ceusa(s) and menner es steled.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and menner steled. 29a, Cartifian Medicai (Check only one) 29b. Signatura and pair of certifier 29c. Licansa numbar 29d. Date signed (Month, Day, Year) 30. Name end addrass of person who completed cause of deeth (Itam 23e) (Type, Print) Jefferson Blud. Smithsburg, Ind Vincent Tone 31. Data filed (Month, Day, Year) 32. Registrar's Signetura State SEP 03 Deper Registrar

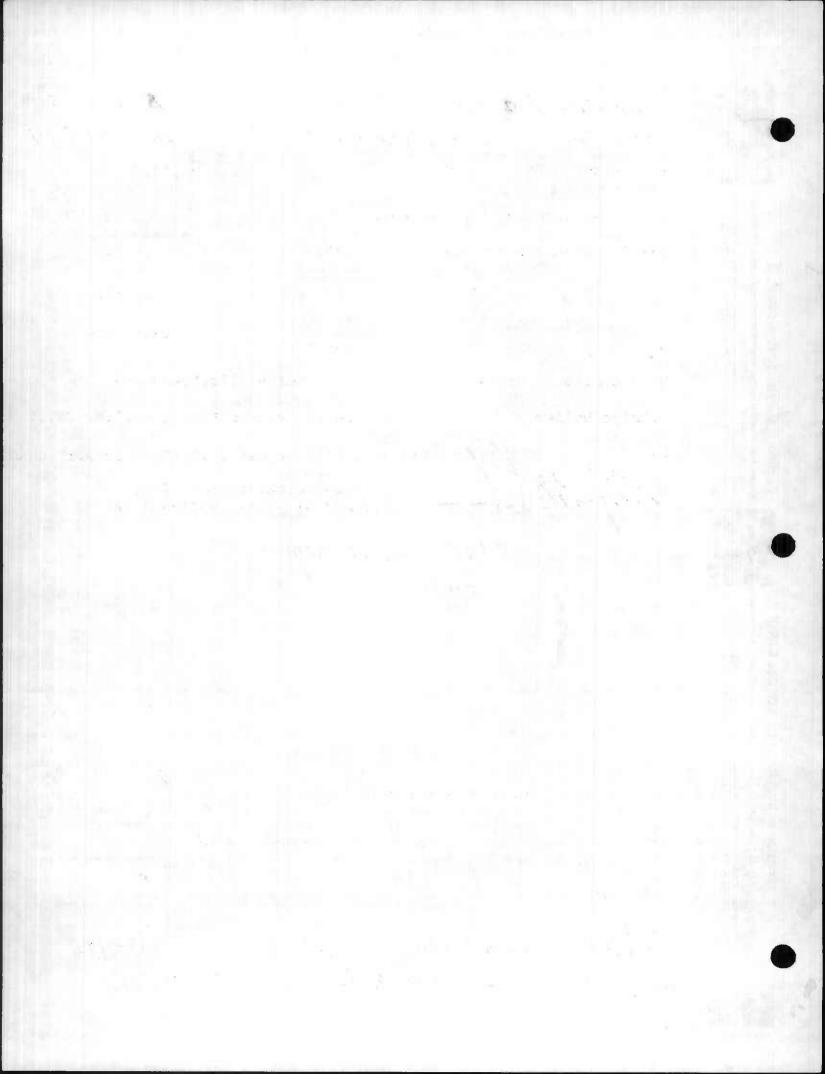


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2:15 pm -RANCES ElizA Dett /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street a Examiner BALTIMURE HOSPITAL BALTI MORE 8. Date of Birth (Month, Day, Year) June 28,1930 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 68 Months Days Hours 1□M 2₩F 215-26-1200 MD Director Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits "natural", or itema 23a or 28a-f show MD 1 ☐ Yes 2 No Washington Big Pool Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12769 Indian Springs Road 21711 U.S.A. Funeral 14. Raca - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify. White þ 3 Widowed 4 Divorced Completed 16e. Decedeni's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) The Medical 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) residence than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 10th grade marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Milburn Kirby Helen Elizabeth Hose 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health a G.Paige Weller 12769 Indian Springs Rd. Big Pool, MD 21711 item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Little Rose Hill August 31, 1998 Clear Spring MD 22. Name and Address of Facility Thompson Funeral Home, Inc. P.O.Box 310 Clear Spring, MD 21722

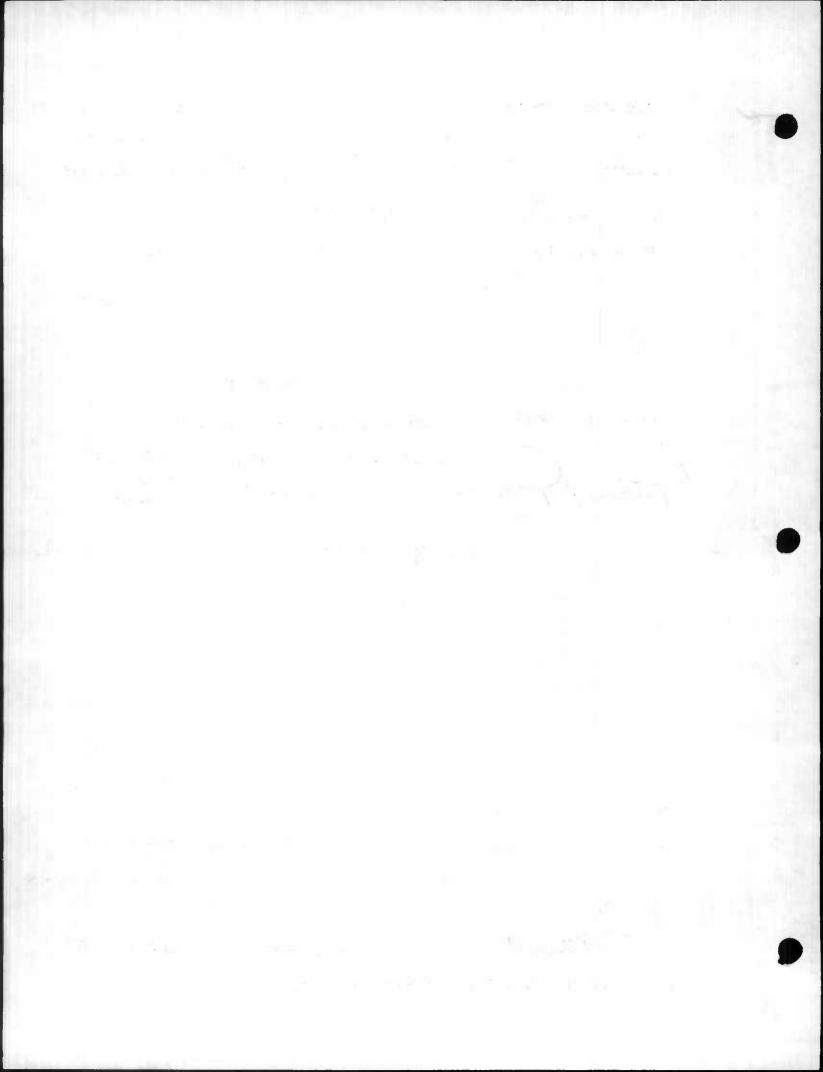
23a. Parti. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or happy family e. List only one cause on each line. **Physician** STAGE L3 LEUKEMIA /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Sepsis Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or Injury thal initiated events resulting in death) Last ue to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Dua to (or as a consequence of): 88 esn ò 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: UNIV OF MARYIMU) 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner r 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Magner of Death 28b. Time of 28d. Describe how Injury occurred 1 Natural 2 Accident 5 Pendino NIA NIA 1 ☐ Yes 2 ☐ No investigation Director: / 6 ☐ Could not be n 24 hours after de re Funeral Directo bletely filled in by the 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifie rison who completed cause of death (Item 23a) (Type, Print)

TRUET, BALTIMORE South GREENE 31. Date filed (Month, Day, Year) 32 Aegistrar's Signature State SEP 0 1 1998 Registrar



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State of Maryland / Department of Health and Mental Hygiene

	Decedent's Name (First, Middle, Last)		(	Certifica	ate of	Death	2. Date of Dea	leg. No.		3. Time of De	Ú .		
ian	Mary Catherine W	leber				Se	Month	D	98		AM		
cai ner	4a. Facility Name (If not institution, give stre 6440 Port Tobaco					b. City, Town, or	Location of Death	4c. County	of Death	10.00	LHI		
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	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  AREHART-ECHOLS FUNERAL HOME P.A.												
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory efrest,  Approximate												
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	30. Name and address of person who compl Dr. Daniel Howell,				La Pl	ata, MD	20646						
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St Regist

Physic /Med Exam

Funera Directo

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any Injury or other traumatic event, or Medical Evantmer must be notified at

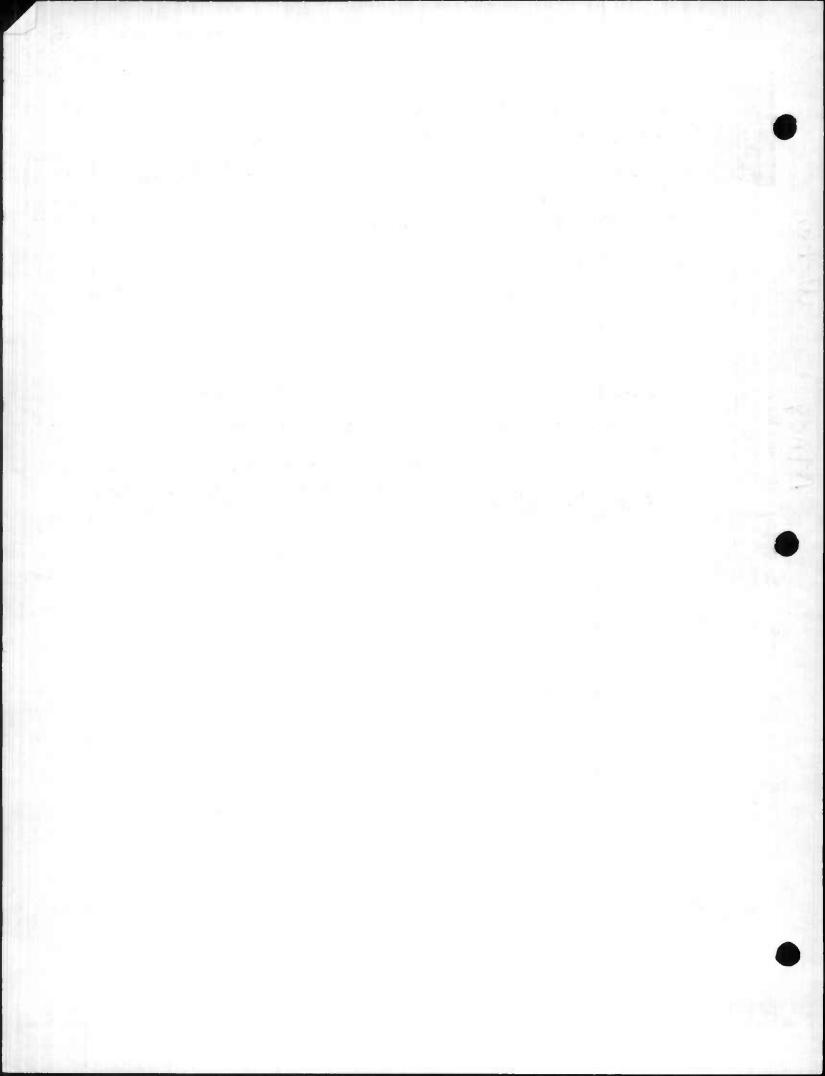
Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer deeth.

To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be deteched for use es the bunel-transit

Division of Vital Records, P.O. Box 68760,

MACY
Baltimore, Maryland 21215-0020

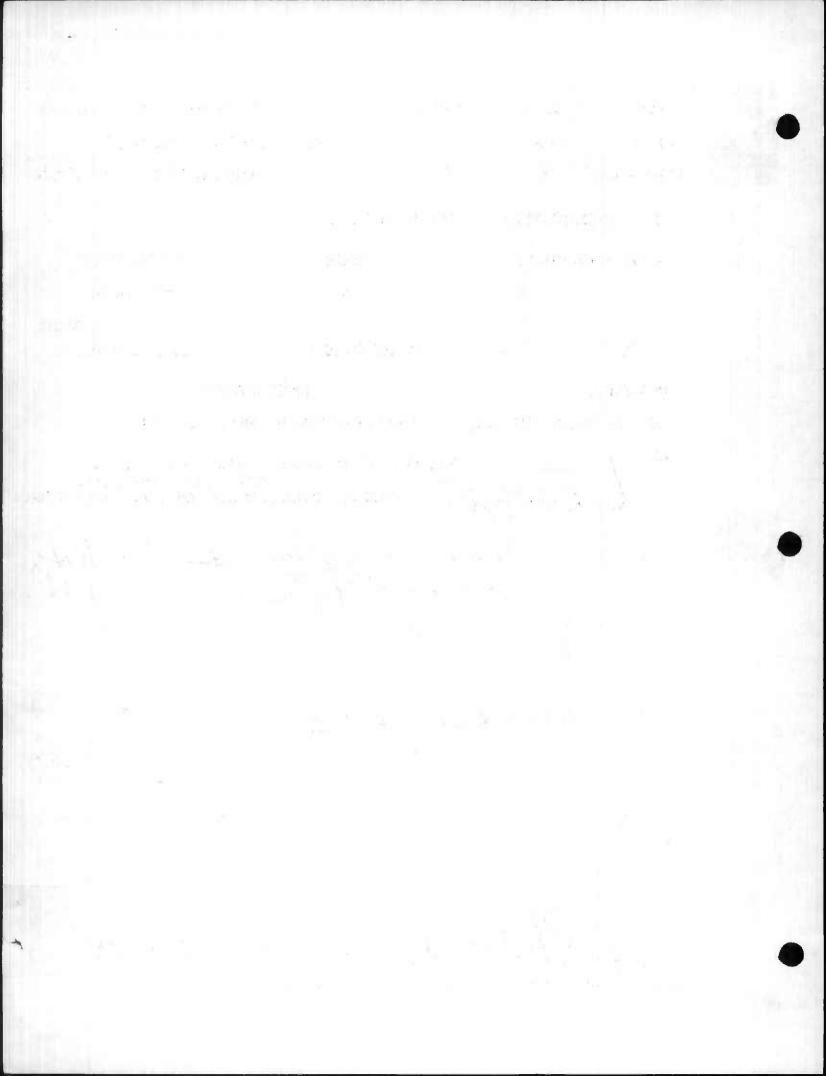


State of Maryland / Department of Health and Mental Hygiene

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Place of injury - At home, ferm, street, fectory, office   28f. Location (Street end Number or Rural (Check only only only)   28c. Place of the time, dete end place, and due to the ceuse(s) end menner as sta (Check only only)   28c. Dete of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner as sta (Check only only)   28c. License number   29c. Dete of my knowledge (Month, Devil)   28c. License number   29c. License number   29c. License number   29c. License number   29c. License number   29c. License number   29c. License number   29c. License number   29c. License number   29c. License number   29c. License number   29c. License number   29c. License number   29c. License number   29c. License number   29c. License number   29c. License number   29c. License number   29c. License number   29c. License number   29c. License number   29c. License number   29c. License number   29c. License number   29c. License number   29c. 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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Mary C. Allen -53 September 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death 901 Hospita, timore nes If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Fereign Country) 8. Data of Birth (Month, Day, Year) Days Hours Months 10 M 10 F 82 213-12-8711 1916 April 17, Georgia Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits n/a 1 Nes 2 No Baltimore 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 10 N. Rock Glen Road 21229 USA 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14 Race - American Indian 11 Marital Status Black, Whita, atc. 1 Never Married 2 Married 1 Yas 2 No If Yes, Give Year or Datas: 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk F.W. Woolworth 10th Grade 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Father's Nama (First, Middle, Last) Ralph Crockett Mary Henderson 19a. Informent's Neme/Relationship (Type, Print) Daughter 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Delores E. Willis 3304 Kerry Road Baltimore, Md. 21207 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematery, crematory or other place) 20c. Location - City or Town, Stata ty⊟Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sept. 23 Woodlawn, Md. Woodlawn Cemetery 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funaral Sarvice Licensee 2501 Gwynns Falls PKWY Baltimore, Md. Erry Trnes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediata Causa (Final diseasa or condition rasulting in death) 24 hours a Levosepsis Dua to (or as a consequance of): Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cerebrovascular accident 24b. Wara autopsy findings available prior to complation of cause of daath? 24a. Was an autopsy performed? Coronary Artery disease

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f ahon

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Norma 23a death

permit. Peges 1 and 2 should be filed within 72 hours effer di Department of Health and Mental Hygiene. Important: if frem 27 is marked other than "natural", or frem any injury or other traumatic event, the Healte France

Baltimore, Maryland 21215-0020

Md.

Director

Funeral

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physicien and the burial-trans the death certificets be execu

Box 68760.

Records,

Vital

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Division

Attending Physician: this death. Hospital or

Examiner Physician/Medical Completed by Be Certification: To

24 hours after Medical To the Fund To the I within 2

State Registrar

Congestive for 25. Was case referred to medical axaminar? 27. Manner of Death 29a. Certifier

1 Yas No

1 WNatural

2 Accident

4 T Homicide

3 Suicida

15 Certifying Physician: To the best of my knowledge, death occurred at tha time, deta and place, and dua to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. (Check only one) 29b. Signatura and title of certifier

5 Pending

invastigation 6 Could not be detarmined

MI

28a. Data of Injury (Month, Day Year)

Heart Failure

29c. Licansa number 10881

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Data signed (Month, Day, Year) September 17 1998

1 Yes 2 No

26 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

1 Yas

28d. Dascribe how injury occurred

Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

26. Pleca of Death (Check only one)

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

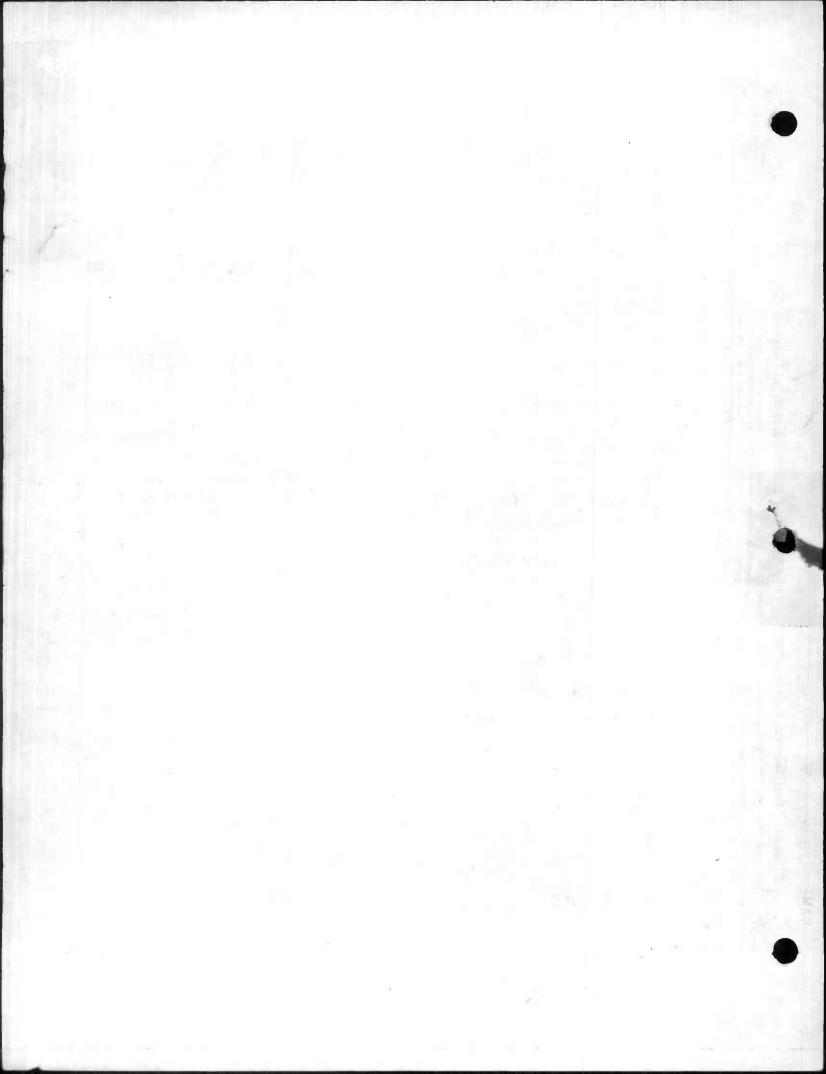
Liberani M.D. Barry 900 caton Ave Baltimore md

Hospital: 1 Junpatient 2 ER/Outpatient 3 DOA

28h Time of

28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify)

31. Data filed (Month, Day, Year) 32. Registrar's Signature SEP 2 1 1998



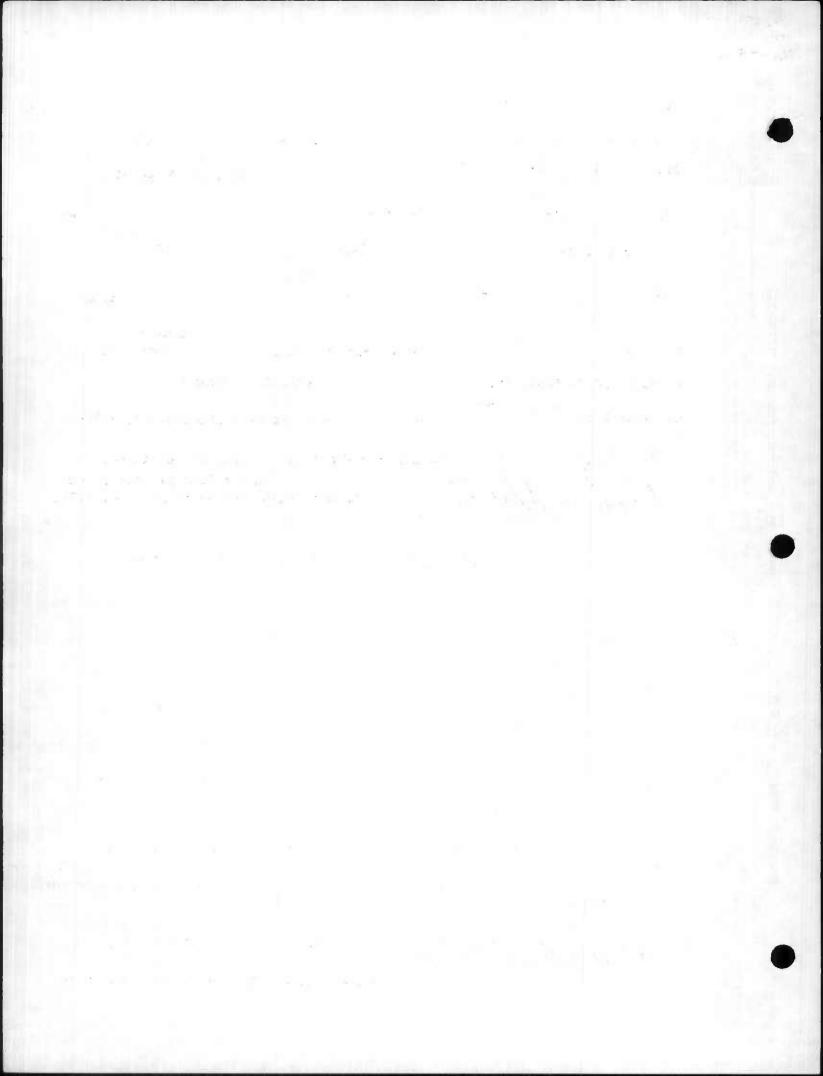
State of Maryland / Department of Health and Mental Hygiene 9 9 9 7

			Cer	tificate o	f Death		Reg. No.	200	C. 1
cedent's Neme (First, Middle,	Last)		16.11						Time of Death
ymond Lamont	Ashe, Jr.							100	:50 A.M.
ecility Neme (If not Institution,	give street end number	7)			4b. City, Town, or	Location of Deeth		of Death	
hns Hopkins Ho	ospital							1	
4-64-7213	6. Sex 7. A	ige (In yrs. le 33	est birthday) Yrs.			(Month, Day		Country)	(Stete or Foreign
		10c City	Town or Loc	eation				10d le	nside City Limits
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Street and Number 4 Brooks Lane							10g. Citizen of t	Whet Country?	
larital Status ↓ Vever Merrled 2  Marrle □ Widowed 4  □ Divorced	Armed Forces od 1 Tyes 25 If Yes, Give	? No	If	Yes, specify Cu	ban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	Ble	ck, White, etc.	
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ementery/Secondary (0-12) h Grade		5+)				Namy .		_	o.
	,		5-11					ne)	
Informant's Name/Relationsh	lp (Type, Print) moth	ner							
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shock, or heert feilure. List of ediate Ceuse (Final ase or condition Iting in death)	nly one ceuse on each	line.						Ons	val Between et and Death
pentielly list conditions, y, leeding to immediate	b	Due to (or	es e consequ	uenca of):					
e. Enter Underlying see (Disease or Injury initiated events ting in death) Last	с.	Due to (or	as a consequ	uenca of):			Ť		
I. Other significant condition	s contributing to death	but not resu	lting In the un	derlying cause	given in Pert I.				cause of death?
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Vac case referred to medical					26 Place of De			CEQ 10.	20110
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lenner of Death	28e. Date of Ini	iury	28b. Time of			1			
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Suicide 6 Could no	nt ho	njury - At hor		et, factory, offic	0	28f. Location (S	Street and Numi	ber or Rural Rou	ite Number
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Signature end title of cartifier									
Mysh	1 No	roli	MY	0	.M.E.		Septemb	er 18,	1998
ame and address of person w	mo completed cause of	death (Item	23a) (Type, F	rint)					
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	ymond Lamont ecility Neme (If not institution, hns Hopkins Ho cial Security Number 4-64-7213 I Residence of Decedent State	hns Hopkins Hospital  cial Security Number	ymond Lamont Ashe, Jr.  acility Name (If not Institution, give street and number)  hns Hopkins Hospital  cial Security Number  4-64-7213  1200 2 F 7. Age (In yrs. In Acident State)  100. County  100. City  100. City  100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. City  1100. 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Certificate of Death  Reg. No.  Condend Name (First, Medials, Last)  Whomat Lamont Ashe, Jr.  Settly Name (Indication, pre-present ever number)  Inst Hopkins (Frost, Medials, Last)  This Hopkins (Post) Number  4.0. Ch, Tam, or Location of Death  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)  Action (Post)

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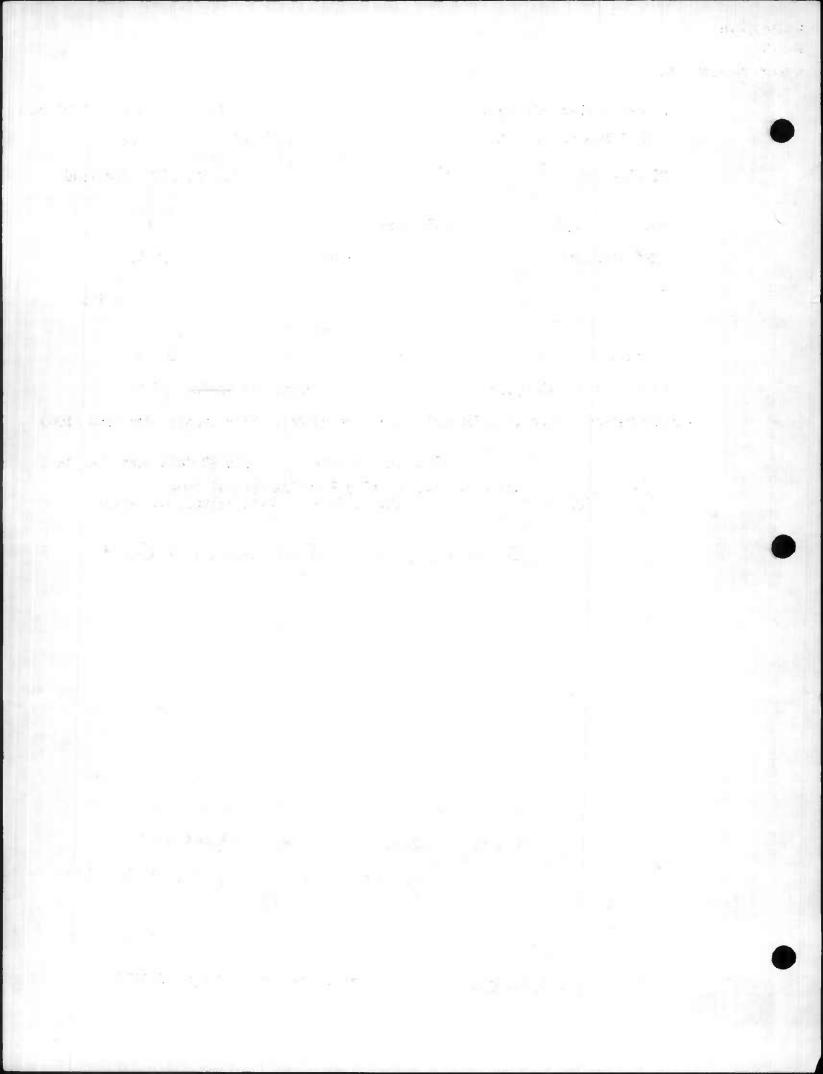
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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 8 8 2 8

Physician	1. Decedent's Name		3 9/22/98	LW				Death	2. Date of De	Reg. No.		3. Time of Death		
I III y o lo la li									Month	Day	Year			
/Medical		Wesley Ar							SEPT.	15, 19		2330 PM		
Examiner	4a Facility Name (II			r)					Location of Deat	h 4c. County	of Death			
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uneral	5. Social Security N	umber 6. Se	x 7. A		last birthday		1 Year	If Under 24 Hr		rth	9. Birthp	laca (State or Foraig		
ector	217-82- Usual Residence of	-1234	QM 2□F	25	Yrs.	Months	Days	Hours Mir		5, 1973	Mary			
9 .	10a. State	10b. County		10c. City	y, Town or L	ocation.					1	0d. Inside City Limits		
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by F	3 Widowed	ed 2 Married 4 Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	: 1 NO		1 🗆 Yes	2 No	Specify:		Specify	Whi	te		
Pa		15. Decedent's Edi			16a. Dece	edent's Usu	al Occup	ation		16b. Kind of B	usiness/Inc	dustry		
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	Howard Wes	sley Antho	ony,Sr.(F	ather	) 12:	21 Le	onar	d Drive	Glen Bui	rnie, Ma	rylar	d 21060		
	20a. Method of Disp				Place of Disp	osition (Na	na of other plac	ce)	Date	20c. Location -	City or To	wn, State		
	Burial 21	☐ Cremation 3 ☐ I	Removal from Stat	0					0710700	Paltimo	no N	lanuland		
4		All Donation 5 Other (Specify)  Baltimore Cemetery 9/19/98 Baltimore, Marylan  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Polymeral Service Licensee												
	NI	Kevin E. Ecker McCully-Polyniak Funeral Home 237 E. Patapsco Ave. Balto., Md. 21225												
	Xi	100			2	37 E.	Pat	apsco Av	e. Balto	) Md.	21225			
	23a Pert 1. Enter the	he diseese, or comp nt failure. List only o	lications that caus	ed the death line.	h. Do not er	nter the mod	e of dyir	ng, such as cardie	ac or respiratory	arrest,		Approximate Interval Between		
an	111111111111111111111111111111111111111											Onset and Death		
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er	disease or condition resulting in death)	n	a. Guns	Due to (e	voun	100.5	1 (	rigui i	wearm	gun Ci	1231			
9				Due to (o	H as e conse	equence or)					1			
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0	Part II. Other signifi	Icant conditions co	ntributing to death	but not resi	ulting In the	underlying o	ause giv	en in Part I.	23b. Dld	tobacco use co	ntribute to	the cause of death		
-	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.								1	Yes 2 No	3 Pro	bably 4 Unknow		
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## Items: 23 part I,27 per MEO G-764 10/6/98 reb Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

LOUIS BACHMAN

State of Maryland / Department of Health and Mental Hygiene Amend: #5 Per FH Film G763 9-29-98RC

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Louis Burton Bachman, Sr.

2. Date of Deeth SEPTEMBER 17, 1998

3. Time of Death 7:10A.M.

10d. Inside City Limits

White

1 ☐ Yes 2 ☐ No

**Funeral** 

Director

Director

Funeral

þ

Completed

7 is marked other than "naturel", or items 23s or 28s-f sho traumatic event, the Medical Experies must be notified at death

12 should be filed within 72 hours effer on and Mentel Hygiene. Is marked other than "naturel" or fram permit. Pages 1 and 2 st Department of Health and Important: If Item 27 la m any Injury or

3altimore, Maryland 21215-0020

**Physician** /Medical Examiner

Examiner Physician/Medical physicia signed by t by Completed Be Certification: To this

or Attending Physician: aftar death. Director: After Hospital 24 hours a • Funeral To the I within 2

Division of Vital Records. P.O. Box 68760.

4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) ANNE ARUNDEL GLEN BURNTE NORTH ARUNDEL HOSPITAL Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, FEB 9, 7. Age (In yrs. last birthday) Deys 17 M 2□ F Months Hours 51 Yrs. Maryland 10a. State 10b. County 10c. City. Town or Location MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of Whef Country? 1021 Minnetonka Road 21144 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorcad 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) Sales Representative Lumber Industry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Louis Bachman, Jr. Easter Dixon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Melinda Bachman / Wife 1021 Minnetonka Rd. Severn, MD 21144 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 20b. Place of Disposition (Name of cemetery, crematory or other plece) Date 20c. Locetion - City or Town, State Metro Crematory, Inc. 9/19/98 Baltimore, MD 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service License 22. Name end Address of Facility Cremation Society of Maryland, Inc.

Dawn F. McDonald

299 Frederick Rd. Baltimore, MD 21228

23a. Pert. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximate Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between Interval Betwe Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of deeth? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

				1 1 100 2 NO	3 Probably 4 A CHIKIT
				24a. Was an autopsy performed?	24b. Were autopsy finding available prior to completion of cause of death?
				1,⊠Yes 2□No	1. Yes 2□ No
25. Was case referred to medical			26. Place of D	eath (Check only one)	
examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 Inpatient 2	XER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residenca 6 ☐ Oth	ner (Specify)
27. Manner of Death  1)(1) Natural 5 Pending 2 Accident Investigation		28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occur	rred
3 ☐ Suicide 6 ☐ Could not be determined		home, farm, sfreet, fect	ory, office	28f. Location (Street and Numb City or Town, State)	ber or Rural Route Number,

29a. Certifier (Check only one) 29b. Signature and title of certifier

1 Certifying Phyelclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E.

SEPTEMBER 18,1998

end address of person who completed cause of death (Item 23a) (Type, Print)

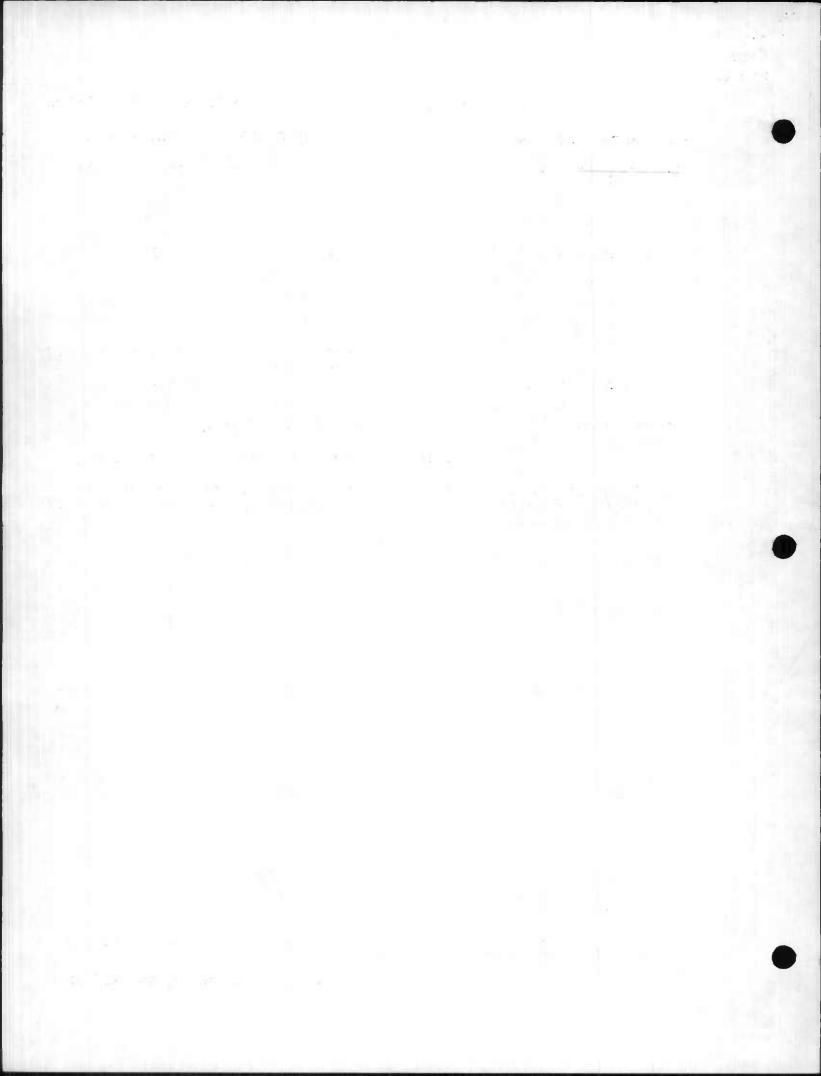
Radentz 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year)

State Registrar

Medical

32. Registfar's Signature

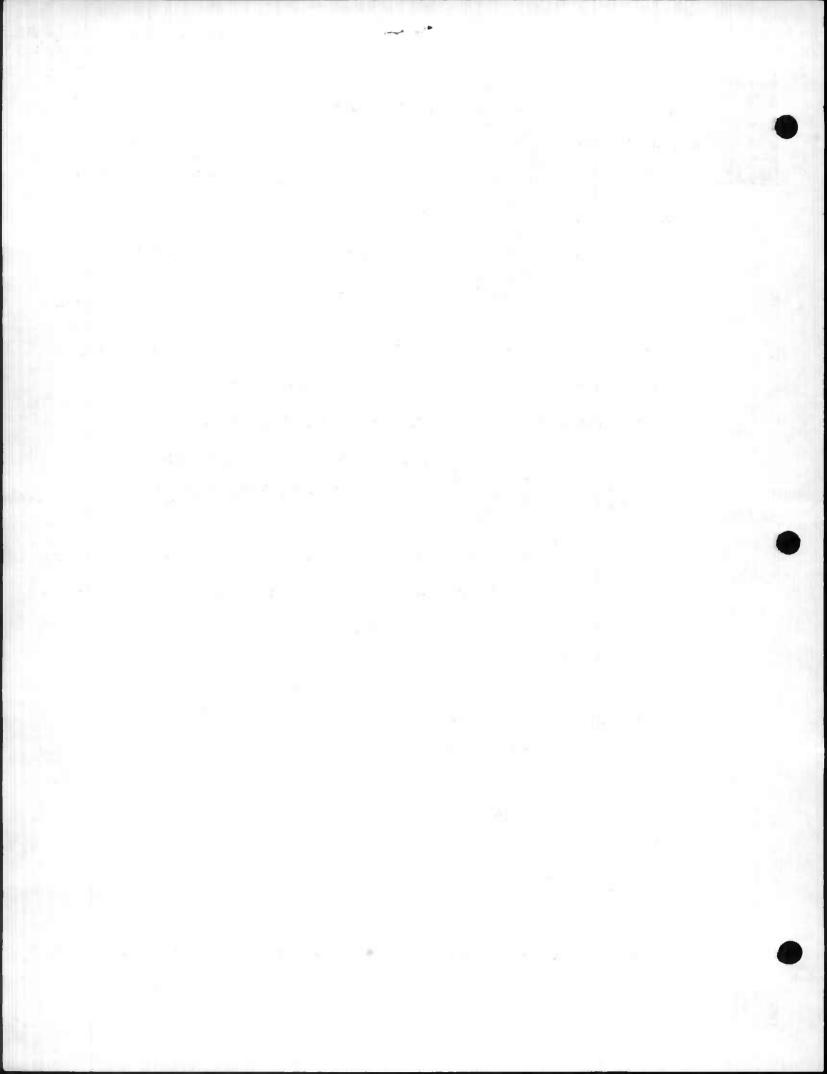




State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Month JR. BOOKER BRADDY SEPTEMBER 19, 1998 18:54 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE OF BALTIMORE SINAL 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth Month, Day, Year) 5/16/24 5. Social Sacurity Number Birthplaca (Stata or Foraign Country) **Funeral** 1 ∰ M 2 □ F Months Days Hours 74 Yrs Georgia 212 20 8313 Director Usual Rasidance of Decedant the Manyland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, tre Modical Examiner must be notified at 1 Yas 2 No BALTIMORE Director MD N/A 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? 2917 ULMAN AVE. 21215 U.S.A. Funeral 12. Was Dacedant Evar In U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Giva Year or Dates: 13. Was Decedant of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian, Black, Whita, atc. 11. Marital Status nit. Pages 1 and 2 should be filed within 72 hours effer cardment of Health and Mentel Hygiene.
ortant: If Itam 27 is marked other than "natural", or ites
injury or other traumatic event, the Medical Examinat 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: AFR. AMERICAN þ 3 ☐ Widowad 4 ☐ Divorcad Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamentary/Sacondary (0-12) College (1-4or 5+) TAILOR ANDERS MEN'S SHOP 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be BOOKER T. BRADDY SR. DORA HOOTEN 19a. Informant's Name/Ralationship (Typa, Print) 19b. Malling Addrass (Straet and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) HATTIE D. BRADDY (WIFE) 2917 ULMAN AVE. BALTIMORE MD 21215 20b. Placa of Disposition (Name of camatary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or MD NATIONAL MEM. PARK 9/24/1998 LAUREL MD 4 ☐ Donation 5 ☐ Othar (Specify) ESTEP 21. Signature of Funaral Service Licansaa CECIL A 22. Nama and Addrass of Facility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217 23a. Part1. Entar the disaasa, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximata Intarval Betwaan Onsat and Deeth Physician /Medical Immediata Causa (Final disaesa or condition rasulting In deeth) A CUTE ANTERIOR WALL MYOCARDIAL Examiner Dua to (or es e consequenca of): Examiner Due to (or as a consaquanca of): DISEASES YEAR Saquantially list conditions, if any, laading to immediata causa. Enter Undarlying Causa (Disease or injury that Initiated avents resulting in daath) Last YEAR HYPERTENSION Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed HYPERCHOLESTEROLEMIA 1 Yas 2 No certificate Division of Vital Hospital or Attending Physician:
24 hours after death.
 Funerel Director: After this certifice Be 25. Was casa refarrad to medical 26. Ptace of Death (Check only ona) examiner? Hospitet: 1 Inpattant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Home 5 Rasidance 8 Othar (Specify) 2 funeral 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred Certification: 1 Naturat 5 Panding Invastigation 1 Yes 2 No 2 Accidant 6 Could not be datarminad 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, offica bullding, atc. (Spacify) 4 Homicida 1 Cartifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Cartifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29d. Date signad (Month, Day, Yaar) SEPTEMBER 19, 1998 mo 30. Nama and makes of person who completed causa of daath (Item 23e) (Type, Print) HOSPITAL OF BALTIMORE, MO 21215 MO SOHN V. SINA WU 31. Dete filed (Month, Day, Year) SEP 2 2 1998 32. Registrer's Signatura State

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Physician OROTHU 4b. City, Town, or Location of Death /Medical 4a Facility Name (If not instruction, give street and number) 4c. County of Death Examiner Baltimor 7. Age (In yrs. last birthday) M Under 24 Hrs. 5. Social Security Number If Under 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1□M 2□F Hours -03-9800 Director **Usual Residence of Decede** the Maryland worls 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar. Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f shaps highery or other traumstic avent, the Medical Examine must be notified to once. 1 Yes 2 No Director PKVIL 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 21234 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 X No Specify Specify: While Py 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Commercial Union Co Elementary/Secondary (0-12) College (1-4or 5+) altimore, Maryland 17 Father's Name (First Middle Last 18. Mother's Name (First, Middle, Maiden Surname) Be Violet RUMA 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wouglas Baltimore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Sept 1 Burial 2 Cremation 3 Removal from State Parkville Gardens 4 Donation 5 Dother (Specify) Mem 21. Signature of Füneral Service Licensee 22. Name and Address of Facility EVOIS CNOPEL ( MIMORUS Rd 8800 Harterd Galtemore 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finat STROKE disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner BLOOD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificate Vital 25. Was case referred to medical examiner? 80 26. Place of Death (Check only one) Other: 405 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of Atter this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? or Attanding 1 Natural 5 Pending 1 | Yes 2 | No /2□ Accident investigation after death 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely illed 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier edical 29b. Signature and title of certiffe 29c. License number 29d. Date signed (Month, Day, Year) 15 30. Name and address of person whe ted cause of death (Item 23a) (Type, Print) Suite 104 Ba 8813 WRM. Minisohn 31. Date filed (Month, Day, Year) SEP 2 2 1998 82. Registrar's Signature State Registrar

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Medica			Bryant,	Sr. ve street and number)				4b. City, Town, or			y of Death	0.52
amine	r		HOPKINS	HOSPITAL				BALTIMOR		N/A		
eral ctor	5	5. Social Security I		Sex 1⊠M 2□F	e (In yrs. la	ast birthday) Yrs.	If Under 1 You Months De	ear If Under 24 Hrs eys Hours Min	. (Month, D			lece (State or Foreig try)
solical Examiner must be notified at		Usual Residenca o 10a. State	of Decedent 10b. County		10c. City,	, Town or Lo	cation				10	0d. Inside City Limit
OTTI	Director	MD	N/A		Ва	altimo				40- 011	148-4-0	1⊠Yes 2□N
č	בַּ	10e. Street and Nu		A			10f. Zip Coo			10g. Citizen of U.S.		uyr
	era	1330 N •	Luzerne	12. Wes Decedent	Ever in U.S	S. 13. V	Was Decedent	of Hispenic Origin? (5	Specify Yes or N	1	A . ca - America	an Indian,
3	by Fur	1 Never Man	rrled 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:		i i	f Yes, specify ( 1 ☐ Yes 2 🖾	Cuban, Mexican, Puer	to Rican, etc.)	Bia	ack, White, of Thy: Bla	
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9	Completed	Elementary/Sec		College (1-4or 5	5+)		mployed	one during most of wo tired)	TKING	N/A		
0	Se C	17. Father's Name	(First, Middle, Las	t)					me (First, Middl	le, Maiden Surna	me)	
F	0	James B	d						Bryant			
		19a. Informent's N	Name/Relationship	(Type, Print)		19b. Mailin	ng Address (St.	reet and Number or R	u <i>ral Rou</i> te Num	ber, City or Town	n, State, Zip	Code)
0000		4 Donation			Ce	nell's	Name and A	al Gardeni ddress of Fecility Carroll	Funeral	Home	, MD	
n		shock, or her			tha death.	Do not ente	er the mode of	W. North	Ave., Ba	errest.	, MD	21217 Approximate
		Immediate Cause disease or conditi- resulting in death)	(Final	y one cause on each li	ne. NAR(	. Do not ente	er the mode of	dying, such as cardle	c or respiratory	errest,	, MD	Approximate Interval Between Onset and Death
Everying	al Examiner	Immediate Cause disease or condition	onditions, immediate derlying of injury ts	a	NAR( Due to (or	COTISM	AND SUBS (uence of):	dying, such as cardla	AVe Bac or respiratory	errest,	, MD	Approximate Interval Between
Eveniner	al Examiner	Immediate Cause disease or condition resulting in death)  Sequentially list or if any, leading to it cause. Enter Und Cause (Disease of that initiated event resulting in deeth)	onditions, mmediate lerlying or injury ts	a	NAR( Due to (or  Due to (or	COTISM / es a consequence es e consequence es e consequence es e consequence es e consequence es es e consequence es es e consequence es es es es es es es es es es es es es	AND SUBS quence of): uence of): uence of):	TANCE ABUSE	c or respiratory	errest,		Approximate Interval Between
Physician Medical Examiner	Physician/Medical Examiner	Immediate Cause disease or condition resulting in death)  Sequentially list or if any, leading to it cause. Enter Und Cause (Disease of that initiated event resulting in death)  Part II. Other signi	onditions, mmediate lerlying or injury ts	a  b  c  d  contributing to death b	NAR( Due to (or  Due to (or	COTISM / es a consequence es e consequence es e consequence es e consequence es e consequence es es e consequence es es e consequence es es es es es es es es es es es es es	AND SUBS quence of): uence of): uence of):	TANCE ABUSE	23b. Di	errest,	ontribute to	Approximate Interval Between Onset and Death
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend: #9 Per FH Film G763 9-22-98RC Reg. No. 2. Date of Death 3. Tima of Death 1. Decedent's Neme (First, Middle, Last) **Physician** 53es 18 SFE /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner MD BAHimore If Under 24 Hrs. 8. Heights Age (In Vis. last birthday) Illennium of bert 8. Date of Birth (Month, Day, 6. Sex If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 249-08-1571 3 Yrs. SC Director Usual Residence of Decedent the Marylend 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Pegas 1 end 2 should be filed within 72 hours efter deeth with the Manylan nent of Health end Mental Hyglane. Intend 27 is marked other than "natural", or items 23s or 28s-f ehow any or other traumatic event, the Medical Executor man to noutred. Mary 1 Yes 2 No Director nore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 6 Funeral 11. Marital Status 12. Wes Decedent Ever In U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien Black, White, etc. 1 Never Merried 2 ☐ Married 1 Yes 2 In It Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0020 1 Yes 2 No Specify à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be own 19e. Informent's Neme/Relationship (Type, Print) (Brother) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health er Important: If Item 27 Is eny Injury or other trait page. 20b. Plece of Disposition (Name of cemetery, crematory or other place) /Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremetion 3 Removal from State John Bapt. Church 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
Joseph L. Rus
2222 W. Nor 21. Signature of Funeral Service Ligensee Ho US ra North 216 Tuen Ito. Approximete Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) AIDS 1 400m Examiner Due to (or es e consequence of) Examiner 18 Liver Cirrhois Co physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting In death) Last Due to (or as a consequence of) 11 Division of Vital Records, P.O. Box 68760, Anasarca Physician/Medical Due to (or es a consequence of): 5428 HTN for use as signed by the e 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings eveilable prior to completion of cause of deeth? bloods 24a. Was an autopsy performed? Completed s certificete has b 2 No 1 Tes 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was cese referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28d. Describe how Injury occurred 27. Menger of Deeth 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 1 Matural 5 Pending 1 Yes 2 No death. Director: A Investigation 2 Accident 6 Could not be 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es steted.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D36494

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29d. Date signed (Month, Dey, Year)

9/19/98

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within 2 To the

30. Name and address of rson who completed cause of death (Item 23a) (Type, Print) me Baltimae

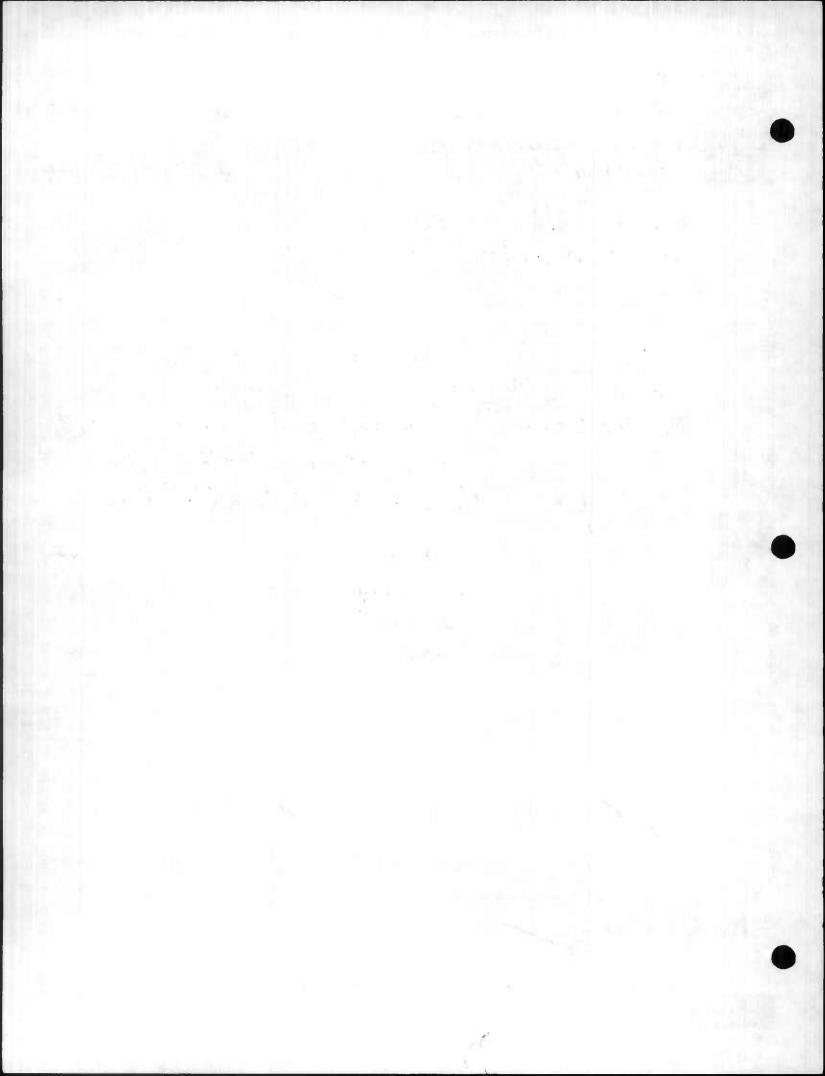
KNESHIMD 4660 WITERS 31. Date filed Month 20ay 32. Registrar's Signature

Registrar

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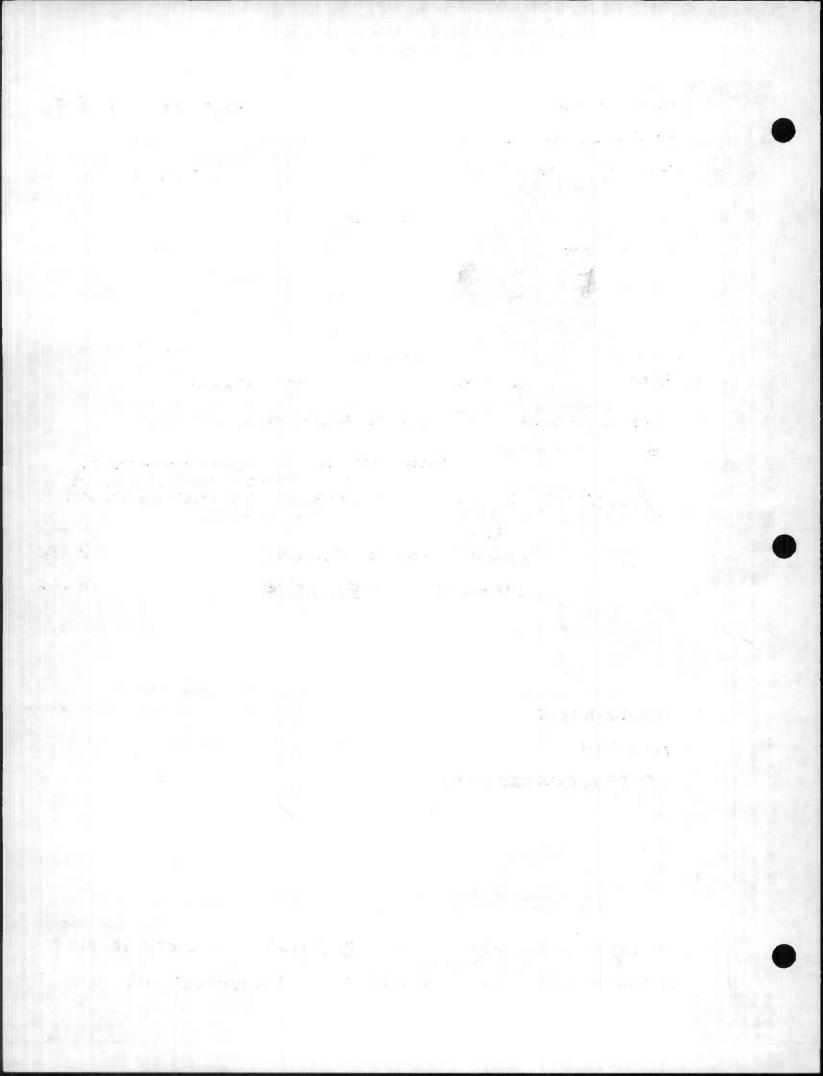
29a. Certifier

29b. Signature end title of certifier



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21. Signeture of Funeral Service Licenses  22. Name and Address of Feolity Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216  23a. Fart. Enter the disease, or confinition that shall be death. Do not enter the mode of dying, such as cerdiac or respiratory errest, why shall disease or condition resulting in death.  Immediate Cause (Final disease or condition resulting in death)  Due to (or es a consequence of):  Due to (or es a consequence of):  Due to (or es a consequence of):  Due to (or es a consequence of):  Due to (or es a consequence of):  Due to (or es a consequence of):  Due to (or es a consequence of):  Due to (or es a consequence of):  Due to (or es a consequence of):  AMYLOID OSIS  ANEMIA  24b. Wes en autopsy performed?  25. Was case referred to medical examples of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	ages ant of t: if it	1 Sprial 2 Crem	etion 3 DR	emovel from	Stete								
25. Was cese referred to medical exempiner?  26. Place of Death (Check only one)  27. Manner of Deeth   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Describe   Descri	Medical Examiner and Examiner edical Examiner	disease or condition resulting in death)  Sequentially list conditions if eny, leeding to immediat ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events	e C		BETE Due to	or es a consec cor es e consec	quence of):						YEARS
25. Was cese referred to medical exeminer?  1	amend for us											t	
25. Was cese referred to medicel exeminer?  1	ad by the detached			tributing to de	eath but not re	sulting in the u	Inderlying (	ause gh	ven in Pert I.				
25. Was cese referred to medical exeminer?  1	s been sig 2 should b pleted b	ANEMI	9									6	Vere eutopsy finding vailable prior to ompletion of ceuse f deeth?
25. Was cese referred to medical exeminer?  1	Page Com	SIP PANO	REA	TEC.	TOMY					1□	Yes 200 N	0 1	☐ Yes 2☐ No
27. Manner of Deeth 1 Neturel 2   Accident 3   Suicide 4   Homicide  28e. Piece of injury - At home, ferm, street, fectory, office 29e. Certifler (Check only one)  29e. Certifler (Check only one)  29e. Signeture end title of certifler, 29e. Date signed (Month, Dey, Year)  28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e. Date of Injury - At home, ferm, street, fectory, office 28e.	Be Be	exeminer?		ospitai:				Ott					
29a. Certifier (Check only one)  29b. Signeture end title of certifier,  29c. License number  29c. Certifier (Check only one)  29d. Date signed (Month, Dey, Year)	Dr. 101	27. Manner of Deeth	Pending	28a. Date	of Injury	28b. Time o	of :	28c. Inju Wo	ry et rk?	1			ify)
29a. Certifier (Check only one)  29b. Signeture end title of certifier,  29c. License number  29c. Certifier (Check only one)  29d. Medical Examiner: On the basis of examinetion end/or investigation, in my optnton, deeth occurred et the time, dete end place, and due to the cause end manner stated.  29b. Signeture end title of certifier,  29c. License number  29d. Date signed (Month, Dey, Year)	a or Alle a sher des d in by th	3 ☐ Suicide 6 ☐	Could not be determined				reet, fector	y, office	THE			umber or Ru	rel Route Number,
	n 24 houn he Funera pletely fille edical (	(Check only 2 M	ertifying Phys edical Examin	er: On the b	asis of examin	owledge, deat etion end/or in	h occurred vestigation	et the ti	me, dete end plece opinion, deeth occi	e, end due to the urred et the time	e ceuse(s) end , dete end pta	d menner es ce, and due	steted. to the cause(s)
	To moo	29b. Signeture end title of	pertifier,				29						
hugan huller ND D 51107 SEPT. 18, 1998		hypin	- hull	- M	D		1	) (	-1107		SEPT.	. 18,	1948



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death SEPT. **Physician** MYRTLE E. 1998 BRUCHEY 12:50 A.M /Medical 4e Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TIMONIUM BALTIMORE STELLA MARIS H Under 1 Year H Under 24 Hrs. 8. Data of Birth (Month, Day, Year) JUNE 14, 1916 Birthplaca (Stata or Foraign Country) MARY LAND 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1□M 2X F Yrs. **Director** 212-76-9872 Usual Rasidanca of Decedant with the Maryland r 28a-f show 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits 1 Yas 2 No Directo MARYLAND N/A BALTIMORE 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda "naturel", or flems 23s or odical Exercises must be 3513 SHANNON DRIVE 21213 permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a any injury or other traumatic event, the Modes Examine 111411. U. S. A. Funeral 12. Was Decedant Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, atc. 1 ☐ Yas 2 🕅 No If Yas, Giva Yaar or Datas: 1 ☐ Nevar Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: WHITE b 3 X Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) OWN HOME 12TH GRADE HOMEMAKER 18. Mothar's Nama (First, Middla, Maidan Sumeme) 17. Fathar's Nama (First, Middla, Last) JOHN D. ROHDE EMMA E. DAUBERT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Steta, Zip Code) PAUL L. BRUNE (NEPHEW) 846 SUE GROVE ROAD, BALTIMORE, MARYLAND 21221 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) OAK LAWN 19/14/98 BALTIMORE, MARYLAND 22. Nama and Addrass of Facility SCHIMUNEK FUNERAL HOME INC. 21. Signatura of Funaral Sarvica Licansas 3331 BREHMS LANE, BALTIMORE, MARYLAND 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximata Interval Between Onset and Death **Physician** CENEBUSE ASERON HAGE Immediete Cause (Final disaase or condition resulting in death) /Medical Examiner Dua to (or as a consequence ot): Sequantially list conditions, if any, laading to immadiate causa. Enter Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consaguanca of): edical Dua to (or as a consequanca of): Physician/M Division of Vital Records, P.O. Box 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has to director, page 2 s 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical axeminer? Be 26. Piece of Daeth (Check only one) axeminerr 1 ☑ Yes 2 ☐ No Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 8 Other (Specify) HOSP/CE 2 2 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manhar of Déath 28b. Tima of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 Yas 2 No invastigation 2 Accidant after desti Director: 6 ☐ Could not be 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At homa, tarm, streat, factory, office building, atc. (Specify) 4 Homicida 24 hours a Furneral 1 Pertifying Phyaiclan: To the best of my knowledge, death occurred at the time, dete end piece, end due to the causa(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. edical 29a. Cartifier (Check only one) To the Within 2 To the F 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifiar 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

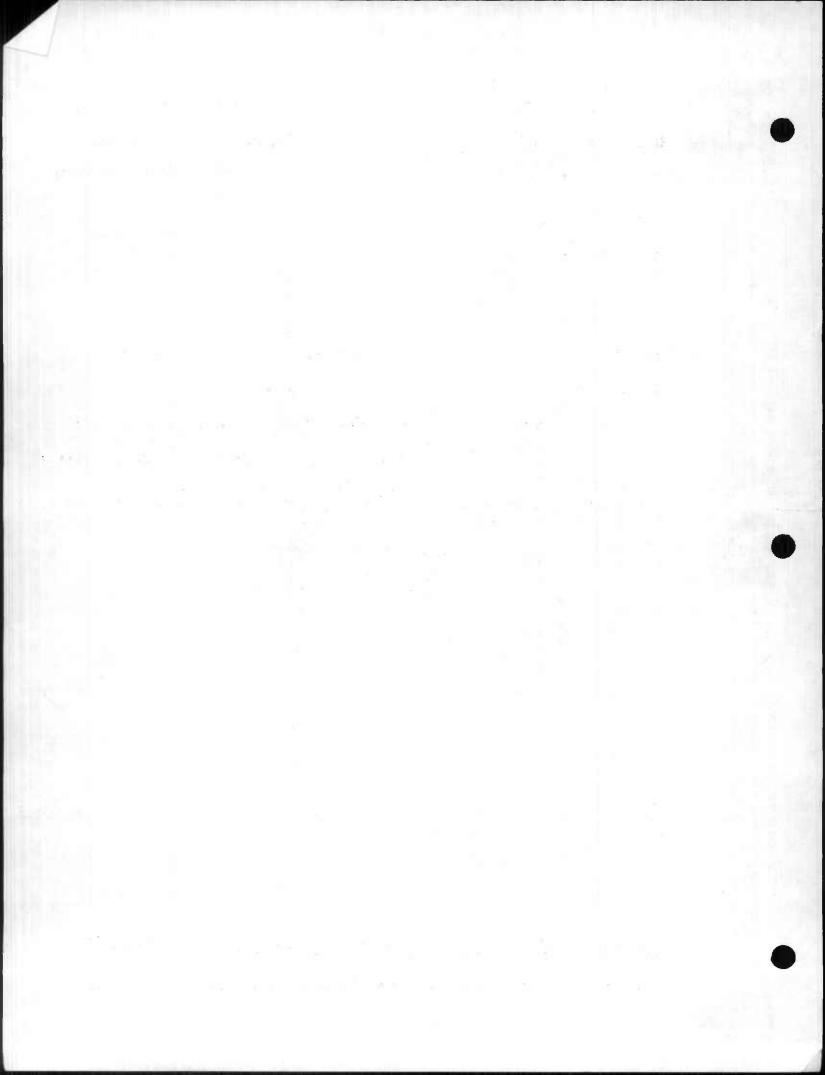
State Registrar

31. Data filed (Month, Day, Year)

32. Ragistrar's Signatura

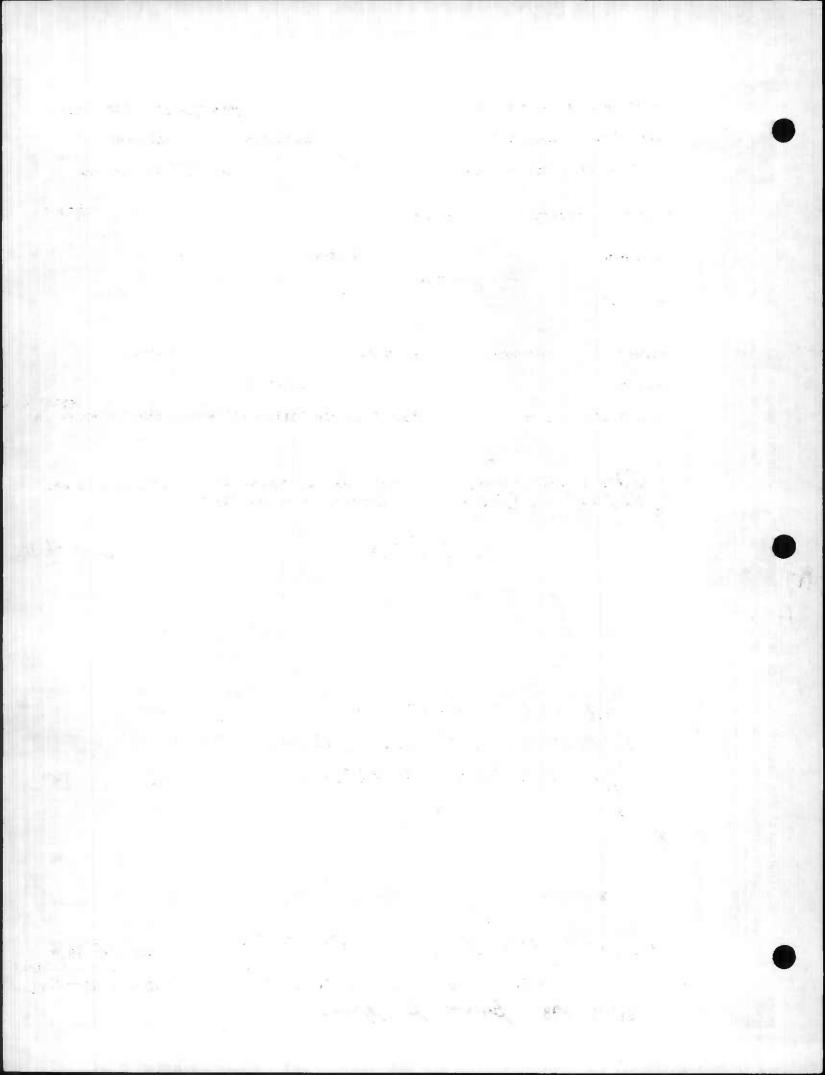
Charles F. O'Donnell, M. D., 111 Hamlet Hill Rd. #408, Baltimore, Md. 21210

**DHMH 16 Rev 6/95** 



	1. Decedant's Nema (First, Middla,	Last)		ertificate of		2. Data of De		٧.	3. Tima of Death		
ysician	James Bernard	Broderick				Month SEPTEMB	Dey	Yeer 1998	1527		
Medical aminer	4a Facility Nama (If not institution, g				4b. City, Town, or L						
	Sacred Heart	•			Cumberla	nd	Alleg				
eral ctor	214-07-2428	. Sax 1	n yrs. last birthd Yrs	Months Days	Hours Min.	nd 8. Deta of Bird (Month, Da Jan. 4	th ly, Year) 1912	9. Birthp Coun unkn	lece (State or Foraign try) IOWN		
	Usuel Residence of Dacedant  10a. Steta 10b. County	10	Dc. City, Town o	r Location				1	0d. Insida City Limits		
to	unknown unkn		unknow						unknows No		
Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhet Coun	itry?		
a o	unknown			unkno	wn		U.S.A.				
by Funeral	11. Maritel Status  1 Nevar Married 2 Married  3 Widowed 4 Divorced	12. Was Decedant Eve Armed Forces? U 1  Yes 2 No If Yas, Give Year or Datas:	r in U.S. nknown	3. Was Decedent of H If Yas, specify Cubi 1 ☐ Yes 2 ☑ No	dispante Origin? (Span, Maxican, Puarto Specify:	pecify Yas or No Rican, atc.)		e - Amaric k, White, White			
Completed	15. Decedant's (Specify only highast of Elementary/Secondary (0-12)	Education greda complated) Collega (1-4or 5+)	16a. De (G	16a. Decedant's Usuel Occupation (Giva kind of work dona during most of v lifa. DO NOT usa retired)			16b. Kind of Bu	isinass/Ind	dustry		
Com	unknown	unknown	un	known			unknov				
Be	17. Father's Nama (First, Middla, La unknown	51)		12.0	18. Mothar's Nam		, Maidan Sumam	a)			
To	19e. Informant's Name/Ralationship		ailing Address (Street	and Number or Ru	ral Routa Numb	er, City or Town,	State, Zip	Coda)15552			
9300	James Broderick	, Jr.	15	10 McKensi	e Pollo F	Road, Mey	sylvania				
		Ramoval from State	cemetery,	sposition (Nama of crematory or othar pla		Deta	20c. Location -		The first		
	4 Donation 2 Defination 3 Hamboral from State 4 Donation 5 Dothar (Spacify)  21. Signature of Fineral Sarvice Licenseth Contraction State Anatomy Board, 655 W. Baltimore  **Robald S. Wade Director State Anatomy Board, 655 W. Baltimore  Baltimore, Maryland 21201  23a. Part1. Entar tha disaasa, or complications that causad tha death. Do not enter the mode of dying, such as cardiac or raspiretory errast, stock, or hear failura. List only one cause on each line.										
edical Examiner	Immediata Causa (Final disease or condition resulting in death)  Saquantially list conditions, if any, leeding to immadiata cause. Enter Underlying Causa (Disease or injury	b	e to (or es e cor a to (or as e cor	sequence of):				0	24 HOUR		
hysician/M	Part II. Other elgnificant conditions	d	ot resulting in th		van in Part f.	23b. Did	. /	ntribute to	o the cause of death?		
by	CORNA	ARY A	PTER	Y DI	SEASE	24a. Was	an autopsy	24b. Way	ara autopsy findings aileble prior to		
o Be Completed	5/00	EREBRAL	In	MARCTI	ON	10	Yas 2 No	of	mplation of cause daeth?		
BeC	25. Was casa referred to medical			•	26. Piece of Dee	th (Check only	ona)				
	axaminar? 1 ☐ Yas 2 No	Hospital: 1 ☐ Inpatiant	2 ER/Outpa	itient 3LI DOA			denca 6 □Oth		(y)		
Certification:	27. Mannar of Death  1 Natural 5 Panding 2 Accidant Invastigat 3 Suicida 6 Could no	be and Disco of Injury			3c. Injury at Work? 1				al Bouta Number		
	4 Homicide determine	building, atc. (	Specify)			City or To	wn, Stata)				
edicai	29a. Certifier 1 Certifying (Check only one) 2 Medicai Ex	Physician: To the bast of m aminer: On tha basis of ex end manner stated	amination and/o	eath occurrad at the ti r invastigation, in my o	me, dete and placa opinion, daath occu	, and dua to tha rred at the time,	data and place,	and due to	the cause(s)		
Σ	29b. Signature and title of certifier	yund	una	29c. Licans	2495	/ s	29d. Date signe	,	1998		
	30. Nama and address of person when the change of the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same and address of person when the same address of person when the same and address of person when the same address of person when the same address of person when the same address of person when the same address of person when the same address of person when the same address of person when the same address of person when the same address of person when the same address of person when the same address of person when the same address of person when the same address of person when the same address of person when the same address of person when the same address of person when the same address of person when the same address of person when the same address of person when the same address of person when the same address of person when the same address of person when the same address of person when the same address of person when the same address of person when the same address of person when the same address of person when the same address	ocompleted cause of death	h (Item 23e) (Ty	leart P	tospita	6-900	Seton	IC	cumberlay P-Md		

DHMH 16 Rev 6/95

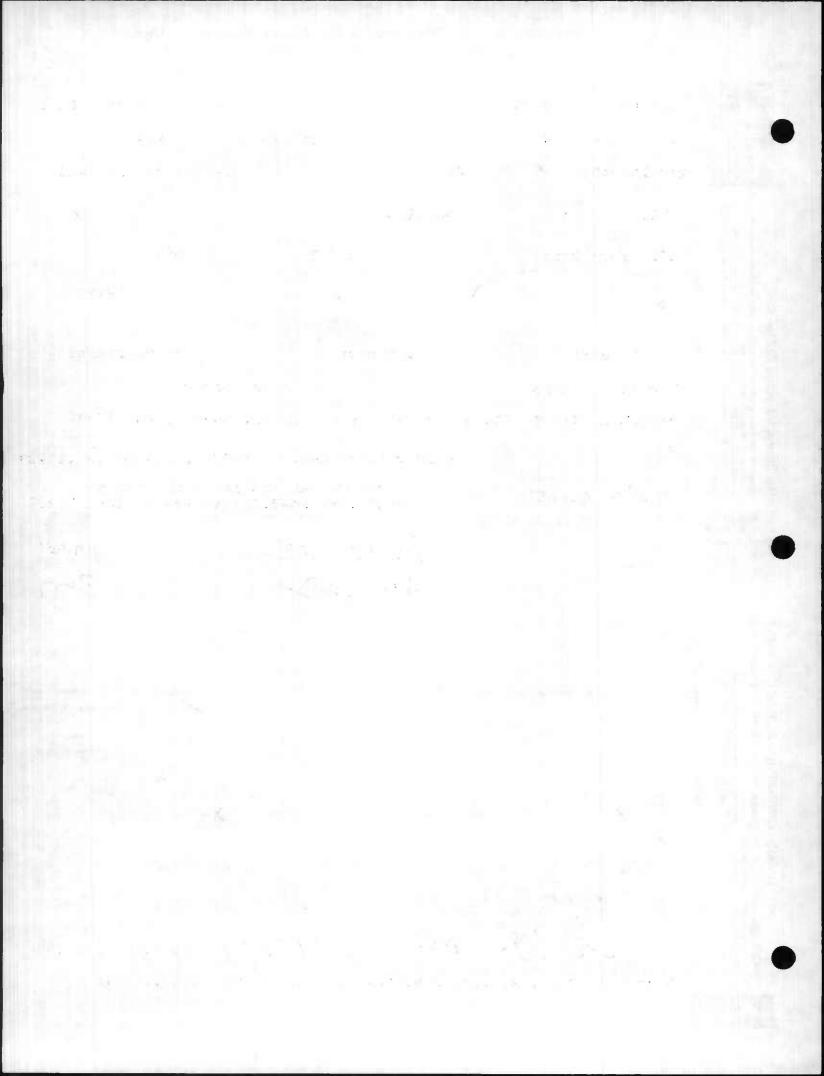


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 20<sup>Day</sup> Month 09-**Physician** 1998 HAROLD L. 9:00 am BURRS /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner 4724 York Road Baltimore | Min. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Yrs. 69 Maryland 217-26-0481 **Director** Usual Residence of Decedent with the Meryland 10a State 10b. Count 10c. City. Town or Location 10d. Inside City Limits r 28a-f show N/A MD. Baltimore 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "naturel", or items 23s or treumstic event, the Majical Examiner must be 4724 York Road 21212 USA permit. Pages 1 and 2 should be filed within 72 hours effer death v Department of Heelth and Mental Hygiene. Important: If frem 27 is marked other than "naturel", or items 23a entry or other treumatic event, the Medical Experiment manall page. Funeral 14. Race - American Indien. 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: WHITE Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: g 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Manufacturer 6 years 18 Mother's Name (First Middle Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Viola Parks Leonard Burrs 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Deborah A. Riddle (Daughter) 430 Deerfield Dr. Hanover, PA. 17331 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State Meadow Ridge Cem. 9 - 23BALTIMORE, MD. 21227 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Henry W. Jenkins And Sons Company . N. Kuth 4905 York Road, Baltimore, Maryland, 21212 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting In deeth) Examiner Due to (or as a Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use es the bunel-mansi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) signed by the a 23b. Did tobacce use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 1 708 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of deeth? been si 24e. Wes en autopsy performed? Completed certificate hes b 1 Yes 2 No 1 Tyes 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No 2 1 | Inpatient 2 | ER/Outpatient 3 | DOA this funerai 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 27. Manner of Death 28c. injury at Work? Certification: After 1 Naturel 5 Pending 1 Yes 2 No deeth. investigation Director: A 2 ☐ Accident 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 4 Homlcide effer • Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, dete end pleca, and due to the ceuse(s) end menner es steled.

2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) within 2 To the 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0 MP September 21, 1998 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Stuart B. Bell, M.D., 3333 N. Calvert Street, Balto., Md., 21218 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature State SEP 2 2 1998 Registrar

DHMH 16 Rav 6/95



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#29c per DVR G763 9/22/98 FW 1. Decedent's Name (First, Middle Last) 2. Data of Death 3. Time of Death 2. Date of Death September 20, 1998 cation of Death 4c. County of Death 1:00 AM Elmer E. Blankenship 4e Fecility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. | (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) XXM 20 F West Virginia 235-28-5518 75 Yrs. June18,1923 Usual Residence of Decedent 10a Stata 10h County 10c. City. Town or Location 10d. Insida City Limits 1 Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 3852 Falls Road 21211 USA 12. Was Decedant Ever in U,S. Armed Forces? 1\TYP as 2 □ No if Yas, Giva Yeer or Datas: Wes Dacedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian. Black, Whita, atc. 1 Navar Marriad XX Married 1 Yas 2XXNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Truck Driver Retail Stores 8 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) A. F. Blankenship Lissie Ellen Davis 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Wife Lucille E. Blankenship 3852 Falls Road, Baltimore, Maryland 21211 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 🕅 Burlal 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) Meadowridge Memorial 9/23/98 Dorsey, Maryland 21. Signature / Funaral Sarvice Licensae 22. Name and Address of Facility Burgee-Henss Funeral Home 3631 Falls Road, Baltimore, Maryland 23a. Part1. En it the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or from failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Immadiata Causa (Final disease or condition rasulting in death) cerebro viscular accident Dua to (or as a consequence of): previous multiple cerebro visculor acidoto Sequantially llst conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaesa or Injury that initiated avants rasulting in daeth) Lest Dua to (or as a consequence of): Due to (or as e consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cigarette smoking 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? hyper Fension 2000 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical axaminar? 26. Placa of Daath (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Yaar) 27. Manner of Death 28d. Dascribe how Injury occurred 28b. Time of 28c. Injury at Work?

**Physician** /Medical **Examiner** 

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**Physician** 

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Pages 1 and 2 s mant of Health ar item 27 i

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Examiner physician sthe burfai-Physician/Medical esn for signed by the a þ been sig Completed

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2 Accident

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Division of Vital Records, P.O. Box 68760, The law requires that the death certificate be Attending Physician: vurs after dea. 24 hours after Funeral Direletely filled in b

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2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) 29b. Signatura and titla of certifier

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1 Cartifying Physician: To tha best of my knowledge, death occurred at tha tima, data and placa, end due to tha causa(s) and mannar as stated.

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Laurel, MD

29d. Data signad (Month, Day, Year)

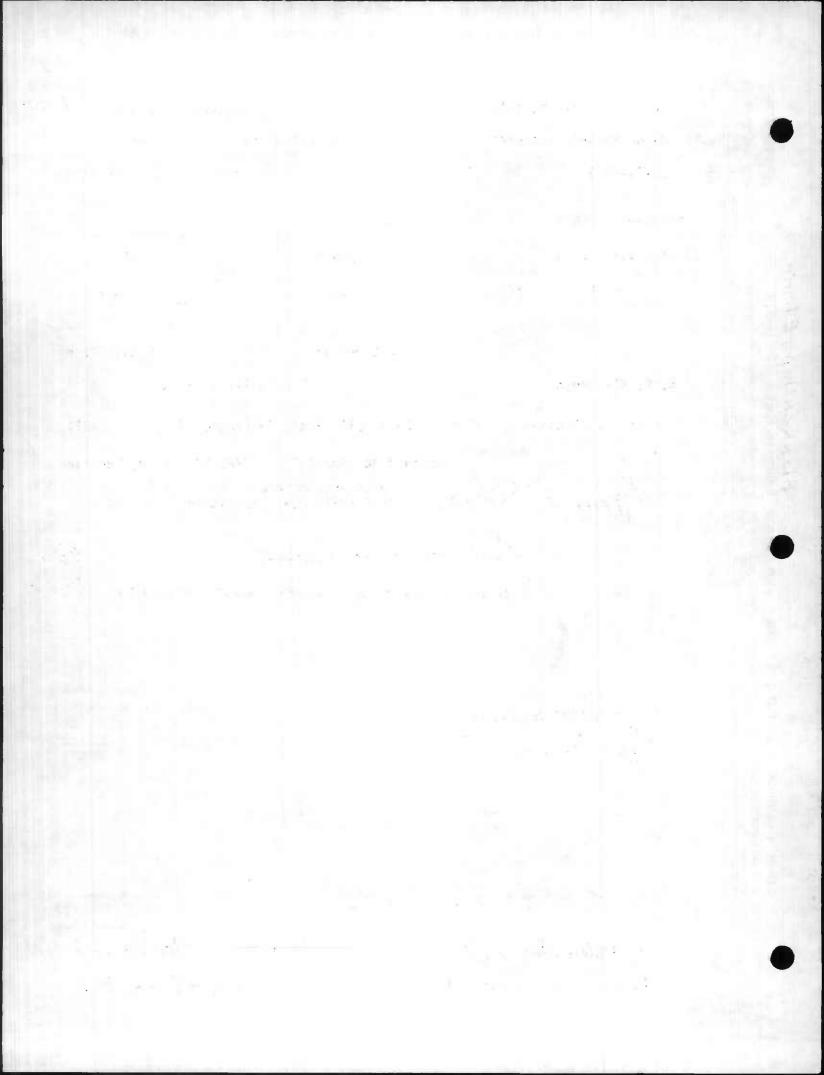
28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

30. Name and addrass of person who complated cause of death (Itam 23a) (Type, Print)

Su 6956 Mayfair 32/Ragistrar's Signature

28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify)

State Registrar

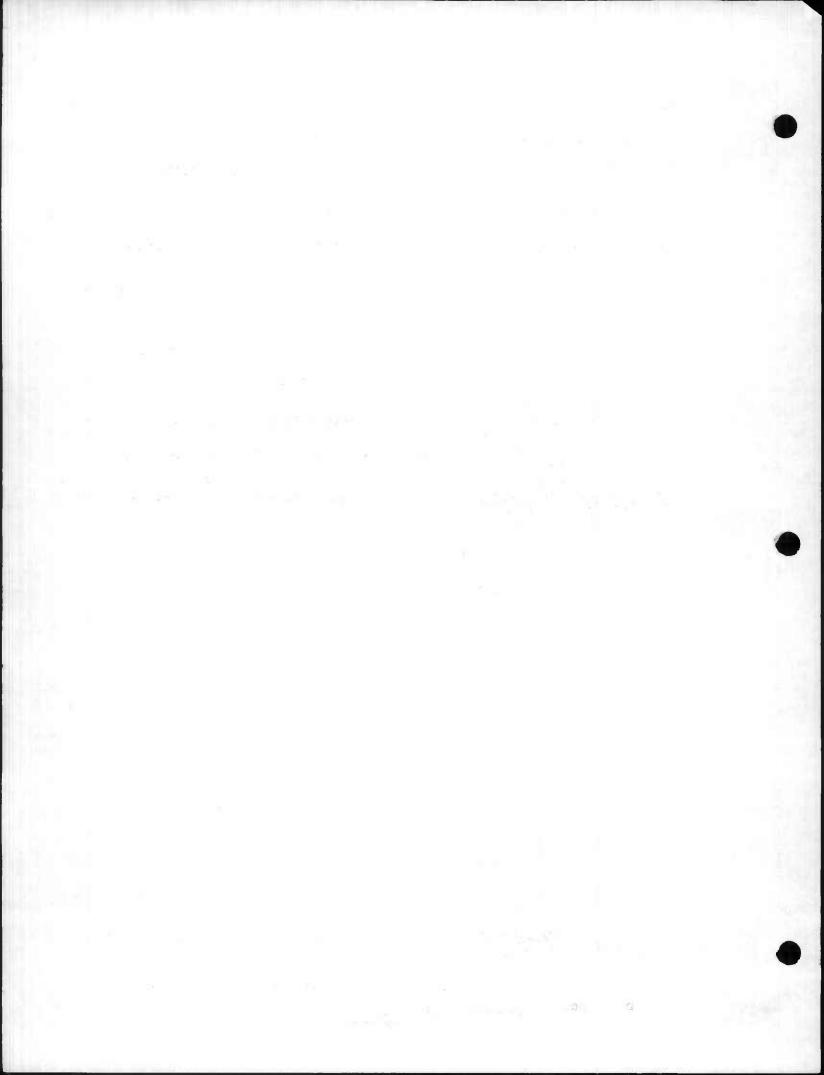


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Deta of Death 3 Time of Death **Physician** 14ey sept. 1998 Ruth G. Berman 8:30am /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore Baltimore 2504 Lightfoot Drive 5. Sociel Security Number 216-07-1882 7. Aga (In yrs. lest birthdey) If Under 1 Yaar 8. Deta of Birth (Month, Dey, Yeer) Aug. 26,1918 Birthplece (Steta or Foreign Country)
 MD **Funeral** 1 M 2 X F Months Deys Hours Yrs. Director Usuel Residence of Dacedant the Maryland 10c. City, Town or Location Baltimore rai', or itams 23a or 28a-f show Examiner mant be notified at 10d. Inside City Limits Baltimore MD Director 1 Yas 2 No 10f. Zip Code 21209 10e. Street and Number 10g. Citizen of What Country? 2504 Lightfoot Drive Funeral death 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Raca - Amarican Indien Bleck, White, atc. filed within 72 hours after 1 Nevar Marriad 2 Married 21215-0020 White 1 ☐ Yes 2 No Specify: "natural", or by 3 Widowed 4 Divorced Yeer or Datas Completed The Medical 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Dacedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) If of Health end Mental Hygiene. If Item 27 is marked other than or other traumstic event, ma Ma Elementery/Secondary (0-12) Collega (1-4or 5+) Housewife Own Home Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) Be Pages 1 end 2 should be nent of Health end Mental Sarah Wilk David Brown 19a. Informant's Name/Reletionship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Coda) Irving Berman/Husband 2504 Lightfoot Drive Baltimore, MD 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Locetion - City or Town, State Burial 2 Cremetion 3 Rame permit. Page Department of Important: If any injury or once. 9/15/98 Arlington Chizuk Amuno Baltimore, MD 5 Other (Specify) 4 Den ineral/Service Ligar 22. Name end Address of Fecility sol Levinson & Bros., Inc. 8900 Reisterstown Road Pikesville, MD 21208 shock, or haart tailure. tha death. Do not enter the mode of dying, such as cardiac or respiretory errest, to on each line. Approximete Interval Batwe Onsat and Deeth **Physician** /Medical Immediate Ceuse (Finel Pneumonia disease or condition resulting in death) Examiner Due to (or es e consequance ot): Examiner Congestive Heart Failure be executed Sequentielly list conditions, if eny, leeding to immadiate cause. Enter Undarlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Due to (or es e consequence of) P.O. Box 68760. Physician/Medicai The law requires that the death certificate Due to (or es e consequanca ot) atten Part II. Other eignificent conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably # Unknown Division of Vital Records, signe be c by 24b. Were eutopsy tindings available prior to completion of cause of deeth? 24a. Wes an eutopey performed? Completed page 2 1 Yes 2 No 1 Yes 2 No certificate Hospital or Attending Physician: Be 25. Wes case reterred to medical exeminar? 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Home 5 AResidence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No this funeral 27. Mannar of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 XNatural 5 Panding after death. investigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be determined 3 Suicide 28a. Place of tnjury - At home, tarm, straet, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 3 4 Homicida 5 To the Hospital o within 24 hours aff To the Funeral Di completely filled in edicai 29a. Certifier 1 X Certifying Phyeicten: To the best of my knowledge, daeth occurrad et the time, dete end pleca, end due to the causa(s) and manner as steted. 2 Medicat Examinar: On the basis of examination and/or investigetion, in my opinion, daath occurred at the time, date end piece, and due to the causa(s) end manner stated. 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) D51426 Sept. 14, 1998 30. Name end eddress of person who complated cause ot daeth (Item 23a) (Type, Print) Elliot s. Rothschild, M.D. 4000 Old Court Road, Suite 301 Baltimore, MD 21208 2. Ragistrar's Signature State

Sparks

**DHMH 16 Rev 6/95** 

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dey Physician 1830 Ralph Whalen Bresnahan September 20 1998 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3382 Horse Head South Laurel Anne Arundel 8. Date of Birth (Month, Day, Year) June 22, 1908 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. Days Months Hours 10 M 20 F 90 Yrs Director 578-01-5529 Washington, DC **Usual Residence of Decedent** the Menyland 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow than "natural", or hams 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 901 Mayo Road 21037 USA Funeral 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. hours efter 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: WWII Specify: White à 3 Widowed 4 □ Divorced "netural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mentel Hyglen important: if them 27 ie marked other tha eny filury or other treumatic event, the pages. Sheet Metal Mechanic Sheet Metal 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 8 Joseph Bresnahan Emma Ray 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Maria C. Morgan - Step-daughter-in-law 901 Mayo Road, Edgewater, MD 21037 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 Donation 5 Dother (Specify) Entemperat Hillcrest Cemetery 9/21/98 Annapolis, MD of Funeral Service Licensee 22. Name end Address of Facility Hardesty Funeral Home, P.A. acklin W 23a. Part | Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiretory errest,

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I Director: Affer in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated.
2 Standard Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) Deputy 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

and address of person who con

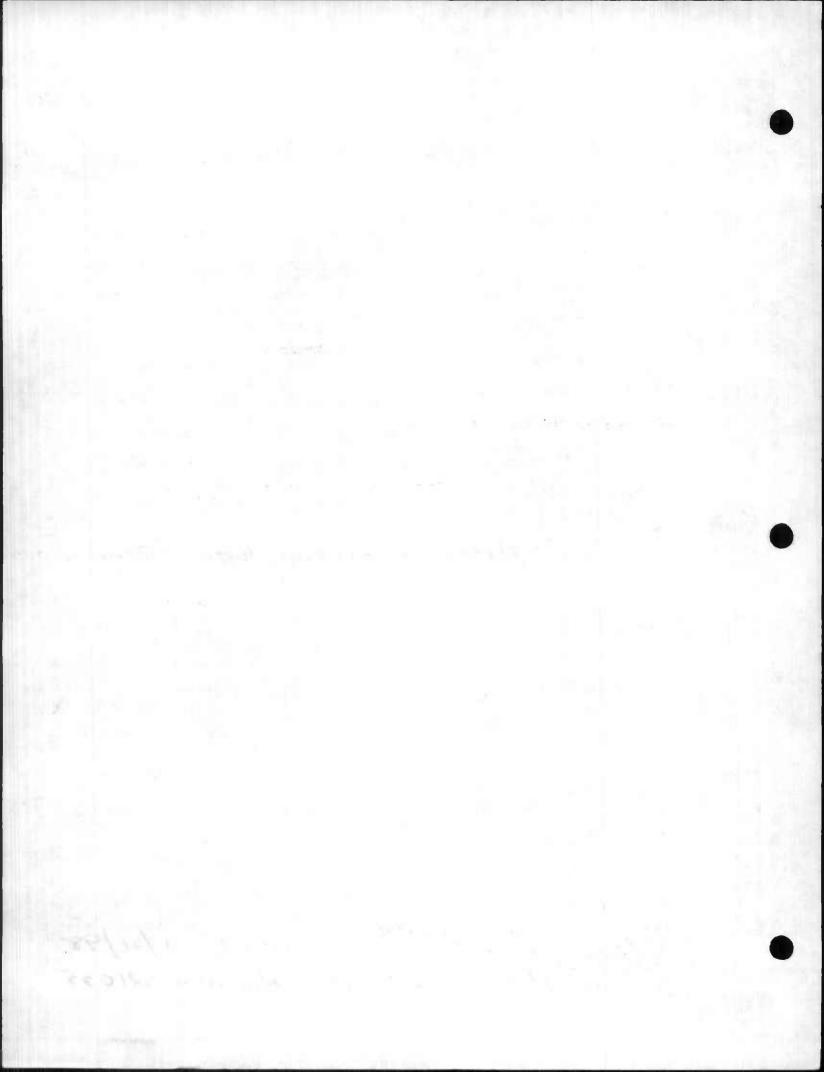
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32. Regisfrar's Signature



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v/Medical	) (11	et Initieted evants sulting in death) Lest	ı	d	Due to	(or es e cons	sequence of):						
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DHMH 16 Rev 6/95

### Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death De CKOSS cotende 12:25 am incen 20 on Location of Death Town. 4c. County of Death 4a Fecility Name (If not institution, give street and 01 B. Date of Birth (Month, Day, Year) JULY 24, 1 5. Social Security Number Birthplece (State or Foreign Country) Days 1**№**M 2□ F 218-40-9143 69 1929 Maryland Usuel Residence of Decedent 10a. Stete 10h Count 10c. City, Town or Location 10d. Insida City Limits Baltimore Reisterstown 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 33 Brookberry USA Rd. Apt. 21136 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian Bleck, White, etc. 11X Never Merried 2□ Merried 1 ☐ Yes 2√☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore Assoc. College (1-4or 5+) Elementary/Secondary (0-12) Janitor of Retarded Citizens 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Hugh O'Conor Cross Helen Martina Flannigan 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) 802 Templecliff Rd. Pikesville, MD 21208 Catherine L. Brown/sister 20a. Method of Disposition 1 ☐ Burial 24 Cremation 3 ☐ Removal from Stata 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, State Metro Crematory, Inc. 9/21/98 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Sarvice Licenses 22. Name and Addrass of Facility F. McDonald Cremation Society of Maryland, Inc. Dated F. McDonald 299 Frederick Rd. Baltimore, MD 21228 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate Interval Batween Onset end Death Immediata Causa (Final diseese or condition resulting in deeth) Cordiomyopath Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Diseesa or Injury that initiated evants resulting in deeth) Lest 23b. Did tobacco use contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No 24b. Wara autopsy findings evellable prior to 24a. Was an autopsy completion of ceuse of death? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 1 Natural 2 Accident 5 Pending investigation

**Physician** /Medical Examiner

any ir

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

MD

Director

Funeral

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Completed

f is marked other than "naturel", or itsms 23a or 28a-f show treumstic event, the Medical Examines must be notified as

with the Maryland

death

72 hours after

Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene. Int: If Itam 27 ie marked other than "!

permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o any Injury or other treumatic eve

Baltimore, Maryland 21215-0020

attanding physician and The law requires that the death certificate be 88 ō signed by the a peen has certificate this

Physician/Medical Examine þ Completed Be P Certification:

Physician; funeral eral Director: After filled in by the funer or Attending death. after Hospital

Division of Vital Records, P.O. Box 68760.

within 24 hours a the 2

Registrar

edical (Check only one) 29b. Signature and title of

29a. Cartifian

3 ☐ Sulcide

4 Homicide

6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify)

29c. License number

1 ☐ Yas 2 ☐ No

Cartifying Phyeician: To the best of my knowledge, death occurred at the time, data and place, and due to the ceuse(s) and manner as stated.

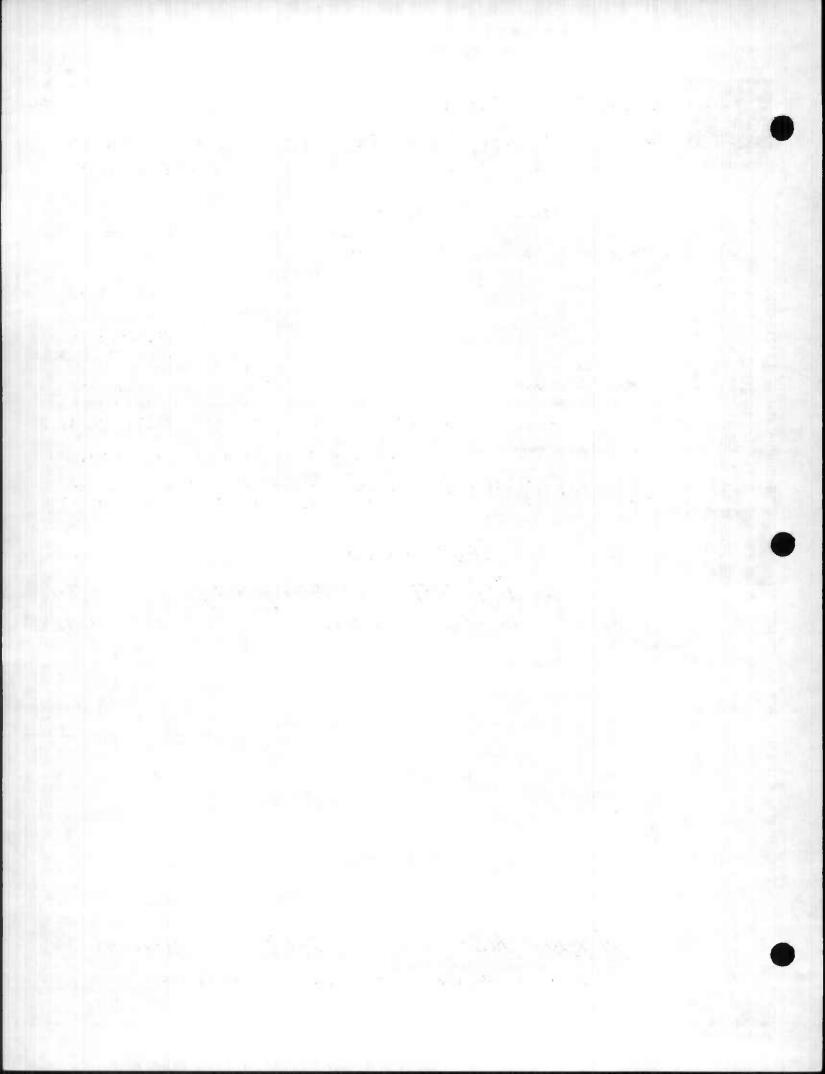
Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, data end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 9-20-98

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

30. Name and address of person who complated cause of daath (Itam 23a) (Type, Print)

NOCHWEST HOSPITAL CONTER AYMAN YOUSSRI

2 2 1998 Registrer Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene STANLEY Certificate of Death COBB ITEM: #5 PER F.H. G764 10-9-98 WR. Decedent's Name (First, Middle, Last)
Stanley Roger Cobb 3. Time of Death 2. Date of Deeth Month Day Year **Physician** 0312 SEPTEMBER 18,1998 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner SHOCK TRAUMA CENTER, University of MD Hosp. BALTIMORE City If Under 1 Year Months Devs 8. Date of Birth (Month, Day, Year) August 26,1956 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Deys Hours 36581 XXX 2 F 42 Baltimore Director Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at MD 1 ☐ Yes 2000 Anne-Arundel Pasadena, Maryland Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 8365 Hilda Avenue 21122 United States Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0020 If Yes, Give Year or Dates: 1 Yes XX No Specify: White Specify. λq 3 Widowed Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) (Give kind of work done duning most of working life. DO NOT use retired) tel Hygiena. Cotlege (1-4or 5+) N/A Elementary/Secondary (0-12) 12th Grade Auto Body Worker Auto 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surname) Peges 1 and 2 should be fill ment of Health and Mentel Health and: If item 27 is marked oth Be Hubert Glenn Cobb Ethel C. Haddon 19b. Mailing Addrass (Street and Numbar or Rural Route Number, City or Town, Stata, Zip Coda) 19a Informant's Name/Ralationship (Type Print) Hubert Glenn Cobb / Father 8365 Hilda Avenue, Pasadena Maryland other Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State ò permit. Pege Department of Important: If any Injury or Voshell Memorial Cardens September 21,1998 Baltimore Maryland 4 Donetion 5 Other (Specify) 21. Signeture of Funeral Service Licensee Victor P. Doda, Jr. Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Final wound disease or condition rasulting In death) Examiner Due to (or as a consaquence of): Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical ettanding physic for use as the b Due to (or as a consequence of) signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peed completion of ceuse of death2 has page 2 1 IV Yes 2 No 100 Yes 20 No cartificate Division of Vital director, 25. Was cese referred to medicel Be 26. Placa of Death (Check only ona) ninar? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nes 2 No 2 1 XInpatient 2 ER/Outpatient 3 DOA this tuneral 27. Manner of Death Date of Injury (Montil), Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Tima of Certification: or Attending Patter death.

Director: After t 5 Pending Investigation Injury 1 Natural 2339 ubjec 17/98 1 Tes 2 No SINO 2 Accident 28f. Location (Gireet and Number or Rurel Route Number, City or Town, State) 3 Duicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Motel 4900 Ritchie in by 4. Homicide Brocklyn Ritchie Hwy Hospital 24 hours a 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Vithin 2 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier SEPTEMBER 19,1998 O.C.M.E. ildress of person who complated cause of death (ttam 23a) (Type, Print) 30. Narr

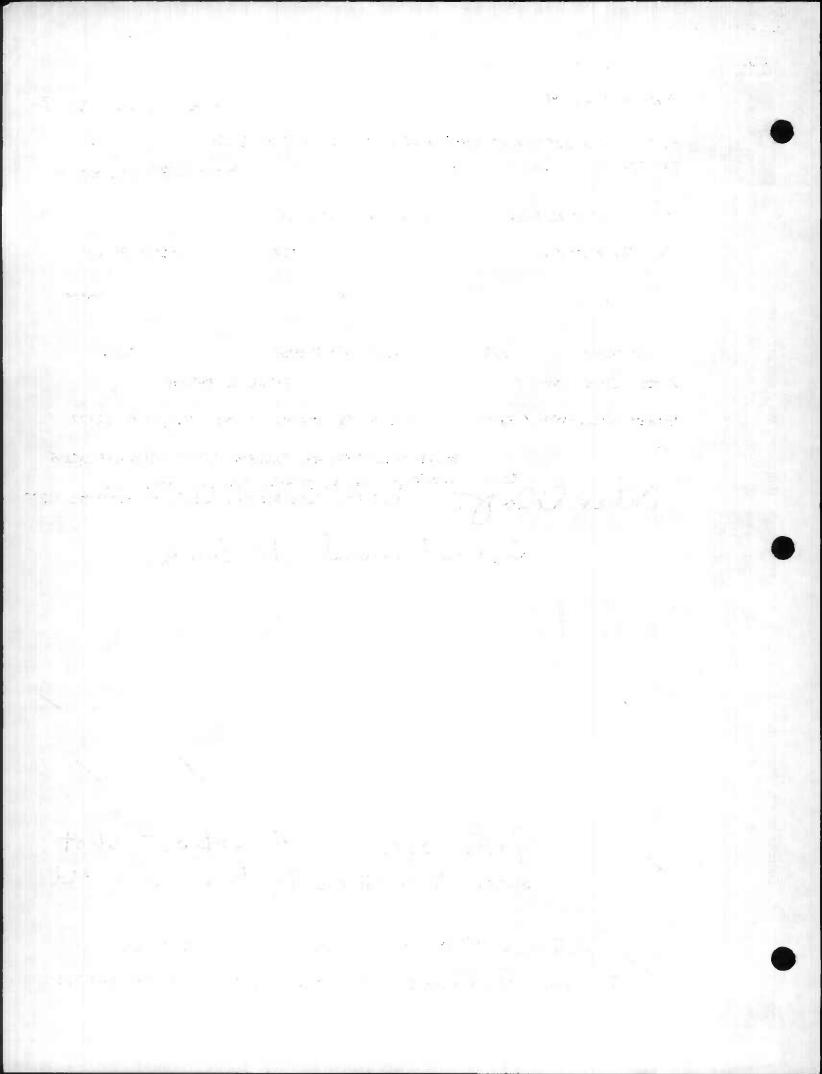
State Registrar

31. Date filed

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estaner \$2. Registrar's Signature

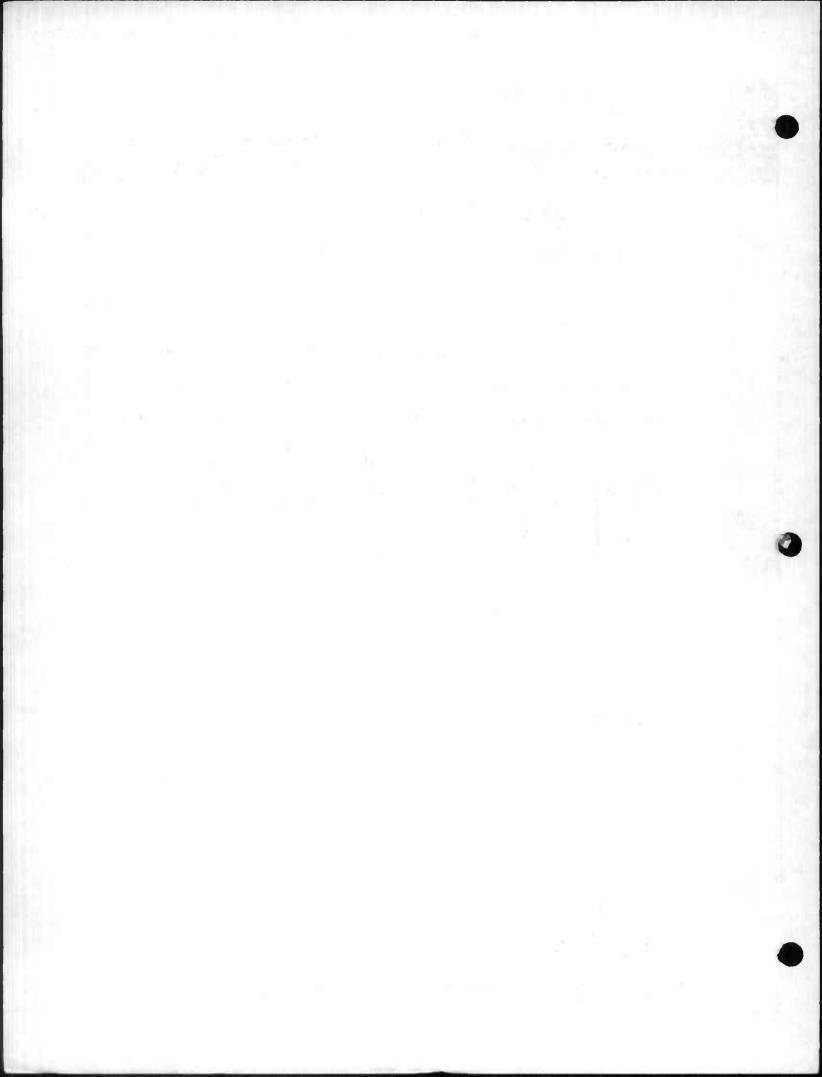
111 Penn Street, Baltimore, Maryland 21201



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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uneral irector		5. Sociel Security 212-32- Usual Residence	0444	Sex 7. Age	83 Y	dey) if Und Months		Under 24 Hrs. Hours Min.	8. Dete of Bi (Month, Di Feb.		9. Birthpleo Country)	e (Stete or Fore
f show	or	10a. State	10b. County Baltim	nore	10c. City, Town							Inside City Llm
23e or 28e	Funeral Director	10e. Street end N 1828 Mc	onkton Ro	ad		10f. Z	21111			10g. Citizen of USA	Whet Country'	?
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at	by Fune		rried 2 Married	12. Wes Decedent I Armed Forces?  1 Yes 2 Yes If Yes, Give Year or Dates:		if Yes, sp	ecify Cuben,	enic Origin? (Sp Mexican, Puerto Specify:	pecify Yes or No Ricen, etc.)		ce - American ck, White, etc.	
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DHMH 16 Rev 6/95



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth **Physician** 4 98 8 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Eacility Neme (If not institution, give street and number) Examiner nera If Under 24 Hrs. If Under 1 Year 9. Birthplece (State or Foreign 8. Date of Birth 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys Min. 238-24-598 1 M 2 KF Yrs. Director Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits is 1 and 2 should be filed within 72 hours after death with the Manylan of Health and Mental Hygene. Item 27 Is marked other than "naturel", or items 23a or 28a-f show other traumatic event, it is ladded Example mail to notified at 1 DeYes 2 □ No Director laryland 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Bleck, White, etc. 1 Yes 2 No It Yes, Give Yeer or Detes: 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: PV 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 10 19a. Informent's Neme/Reletionship (Type, Print) (daughter 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Dapartmant of Haalth and Important: If item 27 is m Place of Disposition (Name of cametery, crametory or other place) Date City of Town, State 20e. Method of Disposition 20c. Location -1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete any injury or 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22, Name end Address of Fecility 2 Ave. 772 pa 23e. Pent/ Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure/ List only one cause on each line. Approximete Intervel Between Onsei end Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) HYPOXEMIA 10 min Examiner Due to (or es/e consequence of): Examiner ASPIRATION burtal-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest and Due to (or es e consequence of): 68760 MyocopoliA2 Due to (or es e consequence of): INFARCTION HOURS Physician/Medical 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. ã 1 Yes 2 No 3 Probably 4 Unknown HYPERNATREMIB by 24b. Were autopsy tindings eveilable prior to 24e. Was en eutopsy performed? Completed ACUTE + CHRONIC RENAL FAILURE completion of cause of deeth? cartificata has MI No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA Aftar this funaral 28e. Dete of Injury / (Month, Dey Year) 27. Menper of Deeth 28d. Describe how injury occurred 28b Time of 28c. Injury et Work? ii or Attending P s after death. ii Director: After 1 Naturel 5 Pending Investigation 1 Tyes 2 No 2 T Accident tha 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 | Homicide To the Hospital within 24 hours a To the Funeral E Hospital 15 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

29c. License number

D01663

29d. Dete signed (Month, Day, Year)

Registrar

29b. Signature and title of certities

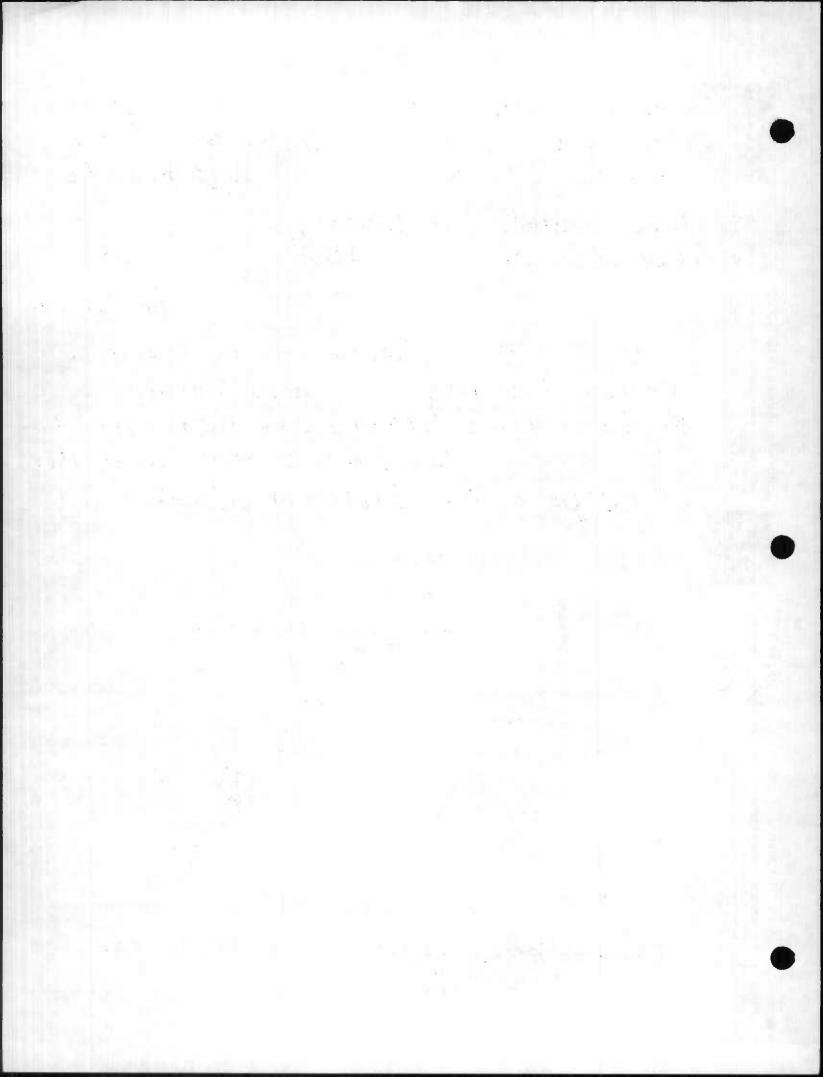
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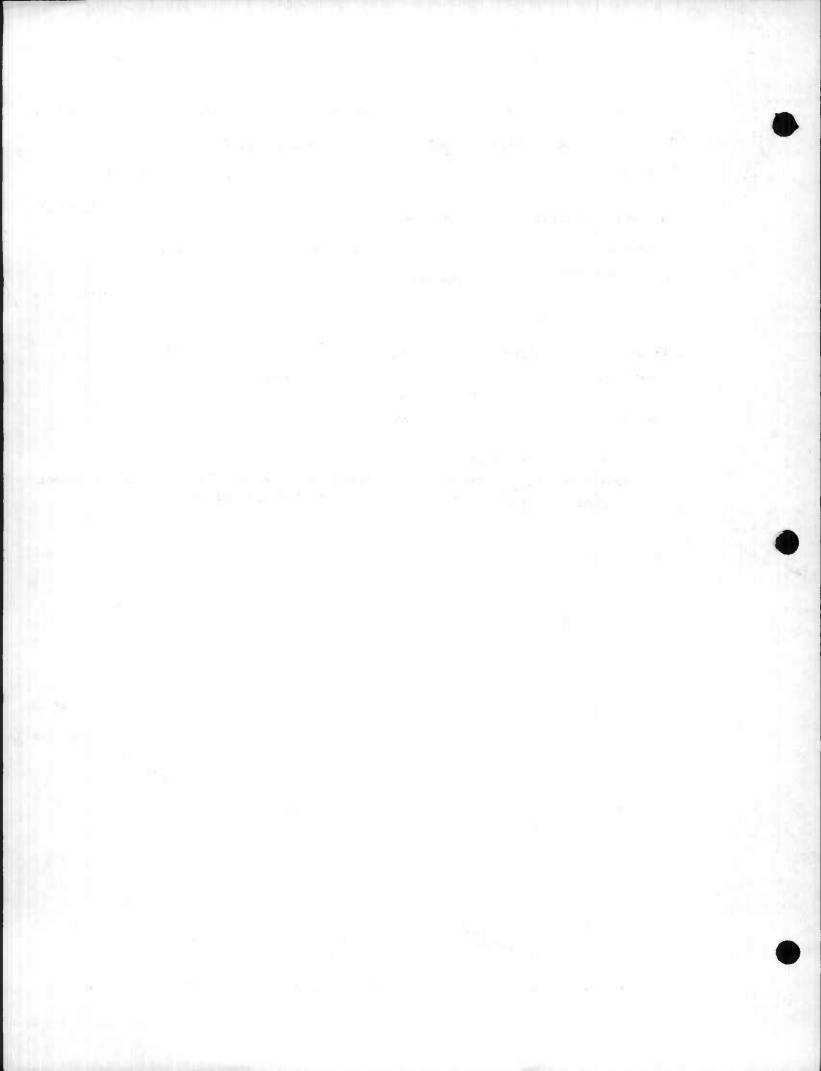
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30. Hame end eddress of person indocompleted cause of death (Item/23e) (Type, Print)

32. Registrer's Signature



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nerai actor		5. Social Security Number 6. Social Security Number 1	9x 7. Age (In )	yrs. lest birtho Yrs	Months		If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di	th by, Year) 29, 1938	9. Birthp Coun Mary	lece (Stete or Forei try) Land	gn
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other traumatic event,		19e. Informent's Name/Relationship (7	ype, Print)		failing Address nknown	(Street	end Number or Rur	el Route Numb	er, City or Town,	Stete, Zip	Code)	
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SUCE.		21. Signature of the all Service Lican	Made, Directo	or			itomy Boa			imor	e Street	Ī
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an		Part 1. Enter the disease, or composition of heart feilure. List only of	one ceuse on each line.	odiii. Bo iiot	ornor are mod	o or dyn	g, obor oo oardioo	or roopirotory o	11031,		intervel Between Onset end Death	
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	icai Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	c		sequence of):							
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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month TEMBER 19, 1998 2:46 PM Dickover Robert Allen 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Baltimore Baltimore Hospital sinai If Under 24 Hrs. If Under 1 Year 6. Sex 1℃ M 2□ F 7. Age (In yrs. last birthday) 5. Social Security Number Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Months Days Hours Min 67 July 30, 517-26-0559 1931 Montana Usual Residence of Decedent 10a. State 10b. County Oc. City, Town or Location 10d. Inside City Limita 1 Yes 2 No Baltimore Cockeysville 10e. Street end Number 10f. Zip Code 10c. Citizen of What Country? 21030 10614 Lancewood Road USA 14. Race - American indian, Biack, White, etc. 12. Was Decedent Ever in U,S. Amed Forces? 1 ½ Yes 2 □ No If Yes, Give Year or Dates: 58 \* -72 \* Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Maritel Status 1 Never Married 2 Married Specify:White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Army Colonel Armed Forces 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Name (First, Middle, Last) John Paul Dickover Edna Cooper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Pnint) Eleanor Dickover/Wife 10614 Lancewood Road Cockeysville, MD 21030 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Dulaney Valley Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State Sept. 23, 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stete Timonium, MD 4 Donation ☐ Other (Specify) 1998 22. Name and Address of Facility .emmon\_Funeral\_Home\_of\_Dulaney\_Valley, vice Licenza Qu. Clary 10 W. Padonia Road Timonium, MD 21093 Bryan or complications the caused he deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, list only one cause of each line. 23e. Part1. Enter the diseas Approximate Interval Between Onset and Death immediate Cause disease or condition resulting in death) Melanomo Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contributs to the causs of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evaliable prior to completion of ceuse of death? 24e. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpetient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident 28c. injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending 1 Yes 2 No investigation

Physician/Medical Examiner by Completed Be 2 funeral Certification: á

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

**Funeral** 

**Director** 

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Itam 27 is marked othe eny Injury or other treumatic event, pines.

**Physician** 

/Medical

Examiner

the Meryland

filed within 72 hours efter deeth with

Robert A. Dickover

dhent Known as:

Division of Vital Records, P.O. Box 68760, or Attending Physician: efter death. Director: After this certifica n 24 hours efter ne Funeral Direct pletaly filled in b To the Hosp within 24 hor To the Fune completely fi

State Registrar

Medical

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end pieca, end due to the cause(s) and manner es steted.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner estated. 29b. Signature and title of carrifier

6 Could not be determined

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

3a) (Type, Print) 30. Name and address of person who completed cause of death (item

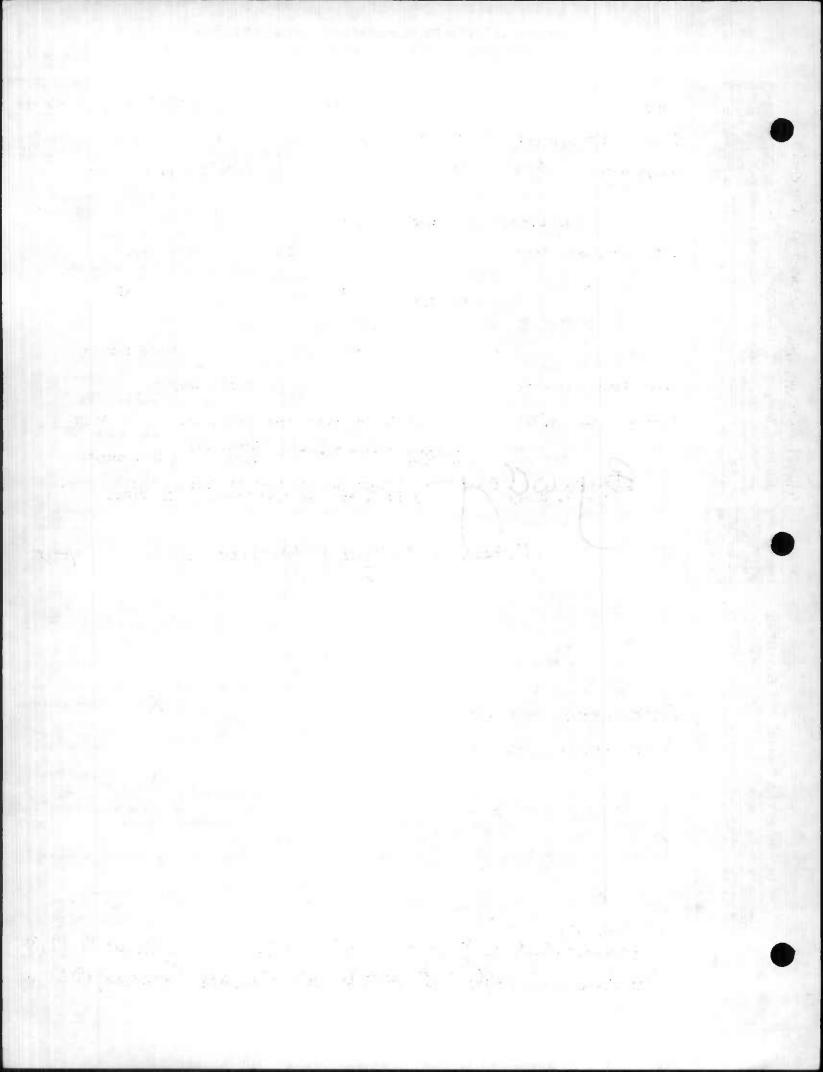
WEST

OHN ANDREW 31. Date filed (Month, Day, Year) 32. 2 2 1998

Registrer's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 16 Rev 6/95



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month Physician RhoOR SUSAN DE Gross SEPT. 3:30 AM /Medical 4a Facility Nama (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 35H BATHHOR Street If Under 24 Hrs. 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Yaar Birthplace (Stata or Foraign Country) **Funeral** 10 M 20TF Days Months: Hours 213-52-2014 49 Yrs. Director mary/one Usual Residence of Decedent 10a. Stata 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 DYES 2 No BALTI MORE Directo Mary/oro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? natural", or items 25s or 21218 35 H USA STIFET 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify Specify: Black 4 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use relired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Social Security Elementary/Secondary (0-12) College (1-4or 5+) AuthorizER ADMINISHET ON 2 YGARS permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Important: If from 27 is marked other 1 any Injury or other traumatic event. In 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Be DE Gross ULUEN BERNICE Tones 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) E. 35th STREET Drughter BALTHORE AND 21218 ERICA Strick/ono 20b. Place of Disposition (Nama of cematery, crametory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from Stata
4 Donation 5 Other (Specify) For The Bin Grid 9/21/98 Woodcher, Kearylows WOODLAWN Concery 22. Nama and Address of Facility CABTMM - HAVELS
5240 KELSTORSOUWN RABO 21. Signature of Funeral Sarvice Lionos 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Finel diseasa or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23h. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yas 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was casa refarred to medical examinar? Be 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yas 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Netural 5 Pending invastigation 1 Yas 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicide 28a. Plece of Injury - At home, larm, street, lectory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier edical (Check only one)

Registrar

31. Data filed (Month, Day, Year) SEP 2 2 1998

29b. Signature and titla of certified

32. Registrar's Signatura

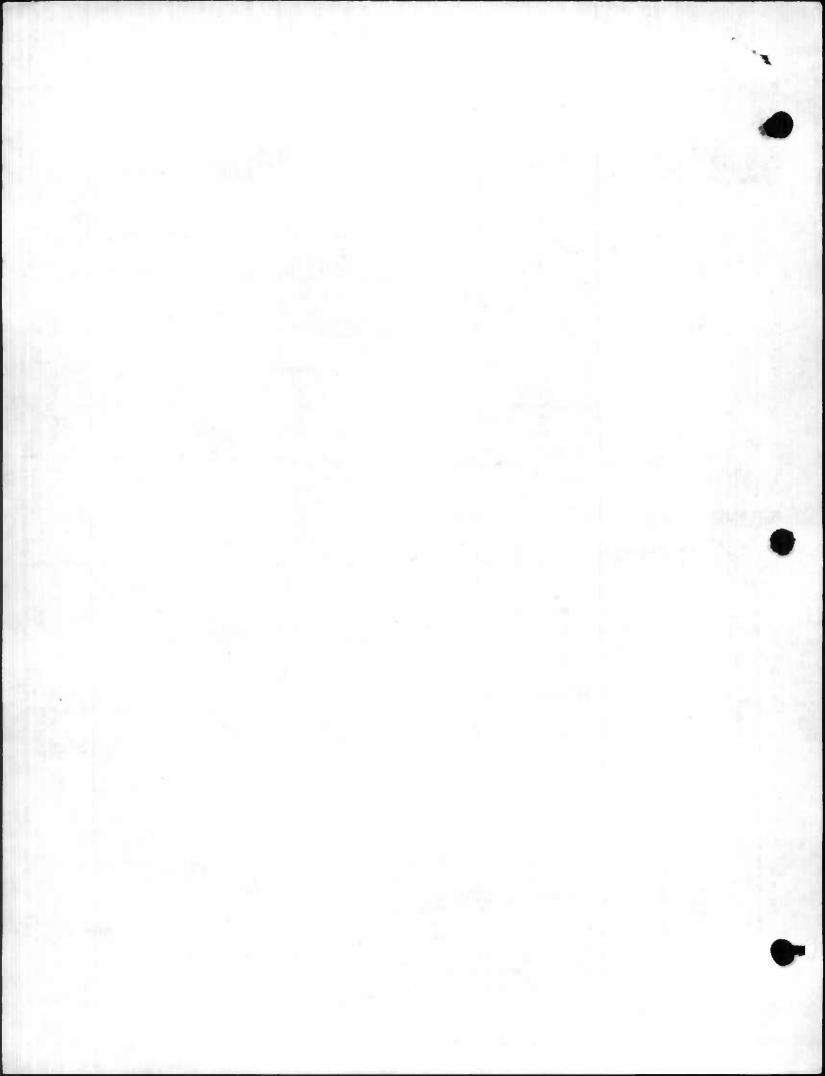
Juliex Grahmer, Mo

29d. Data signed (Month, Day, Year)

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
Julie R. Brahmer, M.D. Johns Hopkins Hospital, Baltimore, MD 21287

**DHMH 16 Rev 6/95** 

29c. License number



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** Ralph James Denkenberger SEPTEMBER 20 1998 9:50am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days tEM 2□F 220-22-8879 69 28, 1928 West Virginia Director Usual Residence of Decedent 10d Inside City Limits 10e Stele 10b Counts 10c. City. Town or Location 1 Yes 2 No Director Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 traumatic event, the Medical Examiner must be 1540 Putty Hill Avenue 21286 U.S.A. Nerns 23s Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 □ Ayes 2 □ No
If Yes, Give
Yeer or Detes: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 ☐ Never Married 2 Amarried 'natural', or Specify: White 1 ☐ Yes 2 No Specify: py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Machinist Bethlehem Steel 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) 88 Michael Denkenberger Lola Feather 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1540 Putty Hill Ave. mportant: If item 27 Mrs. Dorothy Denkenberger/Wife Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stata Pages 75 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removel from State 8 4 Donation 5 Other (Specify) Entombment Dulaney Valley Mem. Grds. 9/23/98 Timonium, Maryland 22. Name end Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1050 York Road Towson, Maryland 21204 ed the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, **Physician** /Medical 4 lars Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es e Consequence of) Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical physic Due to (or as a consequence of): 981 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed page 2 SELNO 1 Yes 1 TYes 2 No funeral director, 25. Was cese referred to medice Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Enpatient 2 ER/Outpatient 3 DOA 1 Ves 2 No 2 this 28c. Injury at Work? 27. Magner of Death 28b. Time of 28d. Describe how injury occurred Certification: 100 Natural 5 Pending investigation

Box 68760 Records, P.O. Division of Vital or Attanding Physician: After death. efter deatl Director: 24 hours e Hospital

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completely To the within 2

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es steled.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number

6 Could not be determined

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a. Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) ST BATINME, MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

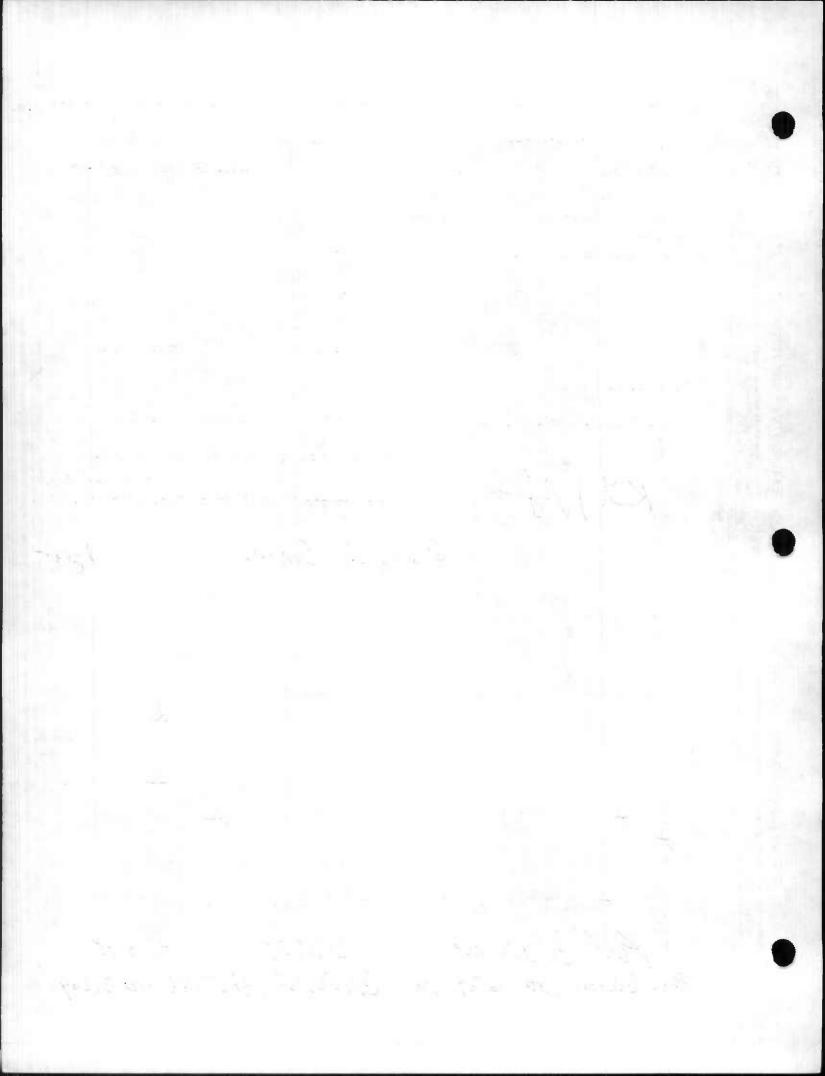
Medical

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State of Maryland / Department of Health and Mental Hygiene

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	Funeral Director	5. Social Security 212-26-5	Number 6.: 102		e (tn yrs. last b		Under 1 Year onths Days			rth Year 0 1927	9. Birthpla Countr Mary L	ace (State or Foreign ny) .and
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4	r tems 23e or 28e-f el sines must be notified.	10e. Street and N	umber st Ridgel	y Rd.		1	21093			10g. Citizen of t	What Counti	γ?
11215-0020	natural, or tema 23a or 28a-f show poles. Examiner must be notified at letted by Funeral Director	3 ☐ Widowed	rried 2 □ Married 4 □ Divorced	12. Was Decedent Armed Forces?  1 X Yas 2 1 H Yes, Giva Year or Dates:			Decedent of is, specify Cul	Hispanic Origin? ( ban, Mexican, Pue Specify:	Specify Yas or Norto Rican, atc.)	o- 14. Rac Bla Specifi	ea - Amarica ck, Whita, al	
21215-0020	yglene. ner then "naturn nt, the Medical Completed	(Spo	15. Decedent's Eacify only highest graceondary (0-12)	ducation ade completed) College (1-4or 5	16:			pation during most of wo	orking	16b. Kind of B		
EN 2	O TO			+1		Post	al Car	rier		Post (	Difice	:
Maryland	D VOIL	17. Father's Name	( <i>First, Middle, Las</i> S. Dashie					18. Mother's Na Freda P		e, Maiden Suman	10)	
	200		Name/Relationship	Type, Print) Shiell/ Wif				and Number or F				Code)
more	nt: if iten		•	Removal from Stata	cemete	ery, cremato	on (Name of ory or other pla ley Ce		Data 9-21-98	20c. Location		
Balt	Department of Important: If eny injury or page.	21. Signature of F	uneral Service Lice	proce				ess of Facility son Fune:	ral Home			rk Road Md.21204
P	hysician	23a. Part1. Enter shock, or he	the disease, of con art lailure. List only	pliodtions that caused one cause on each lin	I tha death. Do							Approximate Intarval Batween Onset and Death
	/Medical xaminer	Immediata Cause disease or condit resulting in death	ion	a	Dive to (or as a	S pho	ceol:	Conco	W			1 year
58750, (cata be awared	burlektransit	Sequentially list of it any, leading to cause. Enter Unc Cause (Disease of that initiated even	onditions, mmediata lerlying or injury	c	Due to (or as a							
ords, P.O. Box 6876	ettending physicie for use as the but clan/Medical	resulting in death	Last	d	Due to (or as a	consequen	ce or):					
0	d for	Part II. Other sign	ificant conditions	contributing to death be	ut not resulting	in the under	tvino causa o	iven in Part I.	23b. Did	I tobacco use co	ntribute to	the cause of death?
P. P.	igned by the ettending be detected for use by Physician/M								1	Y00 2 No	3 Prob	ably 4 Unknown
Records,								-80.16		s an autopsy formed?	avai	ra autopsy lindings ilable prior to apletion of cause aath?
	page 2 Comp								10	Yas 201No	10	Yas 2□ No
	s certificate director, per To Be Co	25. Was case refe	rred to medicat					26. Place of De	eath (Check only	one)		
O A	을 다		5 Pending	Hospital: 1 Inpatie 28a. Date of Injur (Month, Day	ry 28b.	Time of Injury	28c. Inje	ork?	-	how injury occur		)
DIVISION	Director: In by the	2'☐ Accident 3☐ Suicide 4☐ Homicide	investigatio 6 Could not be determined	e one Diseased Init	ury - At home, f c. (Specify)			Yas 2 No	28I. Location City or To	(Street and Numi own, State)	per or Rural	Route Number,
letiosoft at	Funer Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner Puner	29a. Certifier (Check only one)	Certifying Pt	nysician: To the best on miner: On the basis of and manner sta	examination a	e, death oci nd/or investi	curred at the tigation, in my	ima, data and plac opinion, death occ	e, and due to the curred at the tima	cause(s) and m., date and place,	anner as sta and due to	ited. The cause(s)
Total	within 2 To the comple	29b. Signature an	daitle of certifier	1			29c. Licen	se number		29d. Date signe	d (Month, D	lay, Year)
		1	sul (1	laus, n	P		D	36929	8	9/1	8/98	
15	511	30 Nama and add	PLANA	completed cause of d	eath (Item 23a)	(Type, Prin	Chow	350	BAUTI	nre n	15 C	1204
	State Registrar	31. Date filed (Mo.	SEP 2 2	1998 32. Registr	ar's Signature	B.	Soo	uls !				



State of Maryland / Department of Health and Menta	l Hygien
Certificate of Death	Reg. N

28852

Physician	
/Medical	
Examiner	

**Funeral** Director

Baltimore, Maryland 21215-0020

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificete be execu Division of Vital Records, P.O. Box 68760, within 24 hours efter deeth To the Funeral Director: completely filled in by the

State Registrar

31. Date filed (Month, Day, Year) SEP 2 2 1998

1. Decedent's Name (First, Middle, La	ist)		-				2. Date of Dea		Vans	3. Time of Deeth
Justin Lee Dalcin							Month	Day or 00	Year 1002	4:55 P.M.
4a Fecility Name (If not institution, give	re street and number)				4b. City, To	wn, or L	ocation of Death	4c. County	of Death	
,	Sex 7. Age	(In yrs. last b	irthday) If Und	der 1 Year		MOTE 24 Hrs. Min.	8. Dete of Birth (Month, Day	Year)	9. Birth	A place (State or Foreign intry)
215-23-0082 Usual Residence of Decedent	1 DXM 2□ F	20	Yrs.	is Days	Hours	191111.	June 29	,1978		imore, Md.
10a. State 10b. County		10c. City, Tox	wn or Location							10d. Inside City Limits
Maryland Carrol	1 00.	Hamps		7in Code				log. Citizen of	What Cou	1 ☐ Yes 2 No
10e. Street and Number 4004 Shiloh Ave.			101.	Zip Code 210	74			Unite		
11, Marital Status  1X Never Married 2 Married  3 Widowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, s	cedent of pecify Cul	ban, Mexicen	gin? (Sp , Puerto	pecify Yes or No- Rican, etc.)	Bia	ce - Ameri ck, White, by: Whi	
15. Decedent's E (Specify only highest gra	ducation ade completed)	166	e. Decedent's U (Give kind of life. DO NOT	work done	during most	t of work	king	16b. Kind of B	usiness/Ir	ndustry
Elementary/Secondary (0-12)	Coilege (1-4or 5-	-)						Conc	lana a cal	ion
17. Fether's Neme (First, Middle, Last	N/A		Constru	ICCTO			e (First, Middle,	Cons Malden Sumar		.1011
Alfred N. Dalcin,					Debor	ah 1	L. Caspe	er		
19a. Informant's Name/Reletionship (Alfred N. Dalcin,	Type, Print)		b. Mailing Address		et and Numbe	or Or Rur	ral Route Numbe	r, City or Town	5530	
20a. Method of Disposition	or. (radica	20b. Place	of Disposition (f	Vame of			Date	20c. Location		
1 ☐ Buriai 2 ②Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia			op Serv	rice	Corp.	9	/22/98	Towson	, Mar	
Immediate Cause (Final disease or condition resulting In death)	a Naco		Atx a consequence	of):	len					Onset and Death
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	b	Due to (or as a	consequence of	of):						
ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last	C	ue to (or es a	consequence	of):						
	d						ant Buda			
Part II. Other significant conditions of	ontributing to death but	not resulting	in the underlyin	g ceuse y	Iven in Fart I		1 🗆 1		3 Pro	to the cause of death obably 4 Unknow
							24a. Was	en autopsy med?	a	Vere autopsy findings vailable prior to completion of cause of death?
							12	'es 2□No	1	Yes 2□ No
25. Was cese referred to medical examiner?	Hospital: 1 ☐ Inpatier	nt 2 ER/C	Outpatient 3	DOA O	ther	of Deal	th (Check only o		her (Snec	iiy) at scene
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28e. Dete of Injury (Month, Dey	Year) 28b.	Time of Injury	28c. inj			28d. Describe h	ow injury occu	rred	
3 Suicide 6 Could not be determined	28e. Piace of Injurbuilding, etc.		farm, street, fact	tory, office			28f. Location (S City or Tow 100 W. 29		Bal:	ral Route Number,
29a. Certifier 1 Certifying Pr (Check only one) 253 Medical Example 29b. Signature and title of certifier	nyalclan: To the best of miner: On the basis of and manner stat	examination a	nd/or investigati	ion, in my	time, date en opinion, dea nse number	d plece, th occur	rred et the time, o	cause(s) and made and place	, and due	to the ceuse(s)

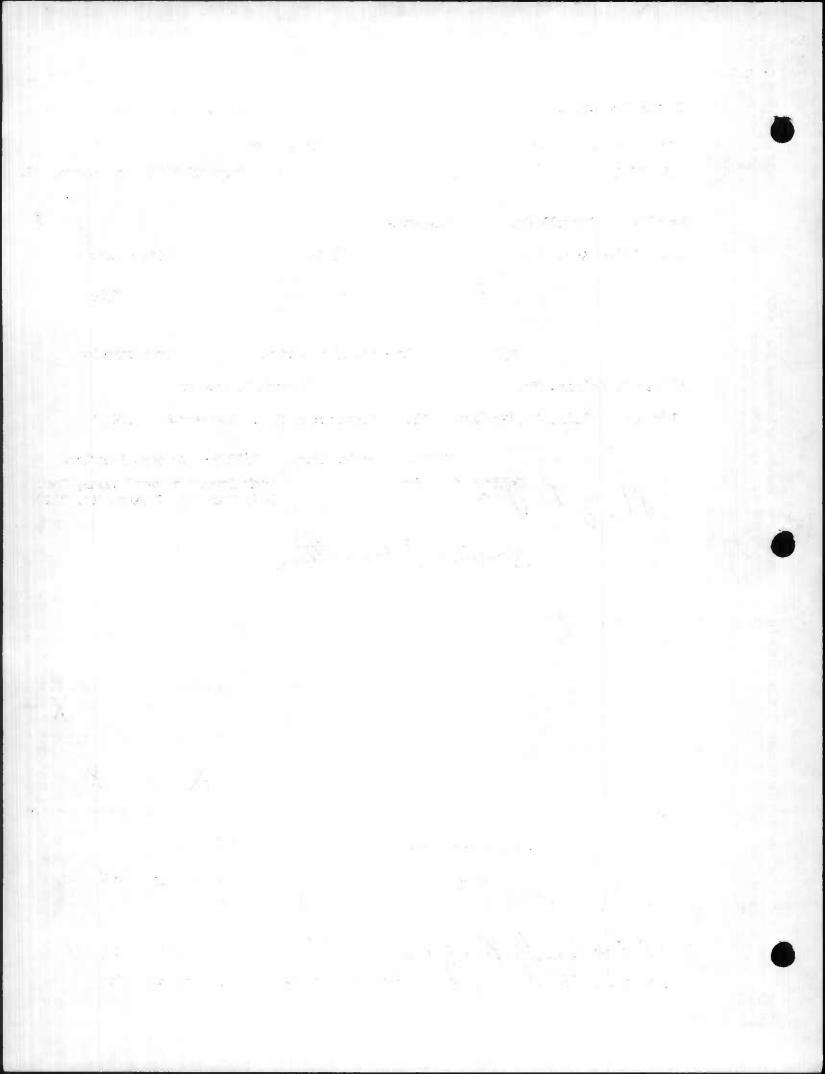
O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

m 23e) (Type, Print)

32. Registral's Signature

SEPTEMBER 21, 1998



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth September Dey 3:45 Am SHIRLEAN C. 15 1998 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth HOSPITAL BALTIMORE SINAI 8. Date of Birth (Month, Dey, Year) 7/1/39 Birthplace (Stete or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 1□ M 2□#F Months Deys Hours Min. Yrs. 241 56 5953 59 N.C Usual Residence of Decedent

21207

Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.)

**Funeral** Director

**Physician** 

/Medical

Examiner

10a State

MD.

10e. Street and Number

the Maryland notified at Directo Funeral þ Completed Be

th and Martial Hygiene.
7 is marked other than "naturel", or frame 23s or treumstic event, the Medical Examiner must be r with 1 and 2 should be Heelth end Mental Item 27 I Pages 1 Department of Important: If It any Injury or o

Physician /Medical Examiner

> 980 signed by the pege 2 s certificate has

Be

Certification: To

Medical

State Registrar 2 Accident

3 Suicide

4 Homicide

(Check only one)

29a. Certifier

Division of Vital Records, P.O. Box 68760, or Attending Physician: funeral director, efter death. Director: Aft 24 hours e Hospital To the Hosp within 24 ho To the Fune completely fi

Examiner Physician/Medical á Completed

3406 ARELLEN CT. 12. Wes Decedent Ever In U,S. Armed Forces? 1 Never Married 2∰ Married 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) Coilege (1-4or 5+) 12 17. Fether's Neme (First, Middle, Last) RAYMOND COBB

HUSBAND

10b. County

19a. Informent's Name/Reletionship (Type, Print)

1 Burial 2 Cremation 3 Removel from State

Pert1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each line.

CECIL A. ESTEP

4 ☐ Donetion 5 ☐ Other (Specify)

21. Signeture of Fuserel Service Licensee

20e. Method of Disposition

Immediate Cause (Final disease or condition resulting in deeth)

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest

N/A

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

1 ☐ Yes 2 ☐ No Specify:

10f. Zip Code

JOHN HOPKINS HOSPITAL REGISTERED NURSE 18. Mother's Neme (First, Middle, Meiden Sumeme)

VIRGINIA WALLINGTON 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 3406 ARELLEN CT. BALTO. MD. 212107

20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Dete WOODLAWN MEM. PARK 9/19/98 22. Name end Address of Fecility

WOODLAWN , MD.

ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Cardiogenic 51
Due to (or es e consequence ot):

10c. City, Town or Location

BALTIMORE

in furction Myocardial Due to (or es e consequence of):

Due to (or es e consequence of):

Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

hyperKalemia

25. Wes cese referred to medical examiner? 1 Yes 2 No 1 ☑ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dev Year) 28b. Time of Naturel 5 Pending

investigation 6 Could not be determined

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy tindings aveilable prior to 24e. Wes en eutopsy performed? completion of cause of deeth?

10d. Inside City Limits

Approximete Intervel Between Onset end Deeth

4 hrs

10g. Citizen of Whet Country?

16b. Kind of Business/Industry

14. Race - American Indian, Bleck, White, etc.

SpecifyAFRO AMERICAN

USA

1 ☐ Yes 2#T/No

2 No 1 ☐ Yes 2 No 26. Plece of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end manner es steted.

| Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end manner stated. 29c. License number 29d. Dete signed (Month, Dev. Year)

29b. Signeture end title of certified MO

P11931/MIT 9191

1 ☐ Yes 2 ☐ No

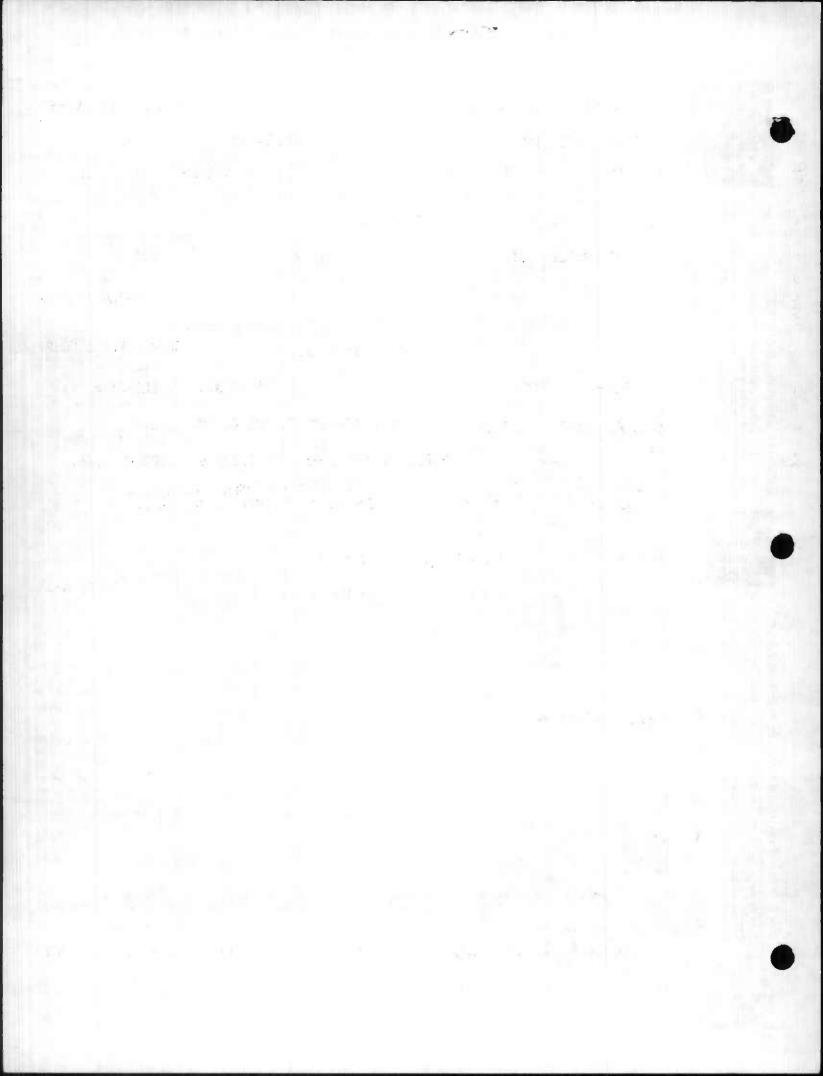
September 15

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)

Hieb Michael 31. Dete filed (Month, Day, Year) SEP 2 2 1998

Sinai 32, Registrar's Signeture

28c. Injury et Work?



State of Maryland / Department of Health and Mental Hygiene

0	0	0	100	1
1	34	5	han	11
E.m.	U	U	V	4

Physicia /Medic Examino	al
Funeral Director	

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Meryland Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "natural; or items 23s or 28s-f show eny injury or other traumatic avent, the Medical Examinet must be notified at once.

**Physician** /Medical **Examiner** 

signed by t his certificate hes bil director, page 2 s this funeral

Division of Vital Records, P.O. Box 68760, Hospital or Attanding Physician: To the Hospital or Attandin within 24 hours after deeth.
To the Funeral Director: Af completely filled in by the fu

Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death EATON 321 pm EMILY SEPTEMBER 13 1998 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth BALTI MORE SECOURS HOSPITAL BON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1 M 2 F 218-22-3050 Yrs. JUNE 26, 1927 MD Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1XXYes 2 □ No Director MD N/A BALTIMORE 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 2722 RIGGS AVE. 21216 U.S.A. Funeral 12. Was Dacedanf Evar in U,S. Armed Forces? 1 ☐ Yes 2 2 100 If Yes, Give Year or Dates; 14 Raca - American Indian. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status Biack, White, atc. 1 Never Married 2 Married 1 ☐ Yes 2 No AFR. AMERICAN Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC 0 HOMES 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middla, Last) THOMAS CARTER EMMA CARTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) VERONICA EATON (DAUGHTER) 3771 BRICE RUN ROAD RANDALLSTOWN MD 21133 20b. Place of Disposition (Neme of cematary, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) LOUDON PARK CEM. 9/17/1998 BALTIMORE MD 22. Name and Address of Facility
ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PLACE BALTO. MD 21217 21. Signature of Furniral Service Licophic 23a. Part1. Enter the disease, or complications that caused the death, shock, of heart failure. List only one cause on each time. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Dua to (or as a consequance of): Versigaen 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy Completed 1 ☐ Yes 2 No 1 Ves 2 No Be 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Yes 2 No Certification: To 1 inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Phyaician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner es steted.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier

e of death (Item 23a) (Type, Print)

TZALFS

32. Registrar's Signature

CHIV

Secoms

3000 W. BALTIMORE

Hospital

50

mo,

21223

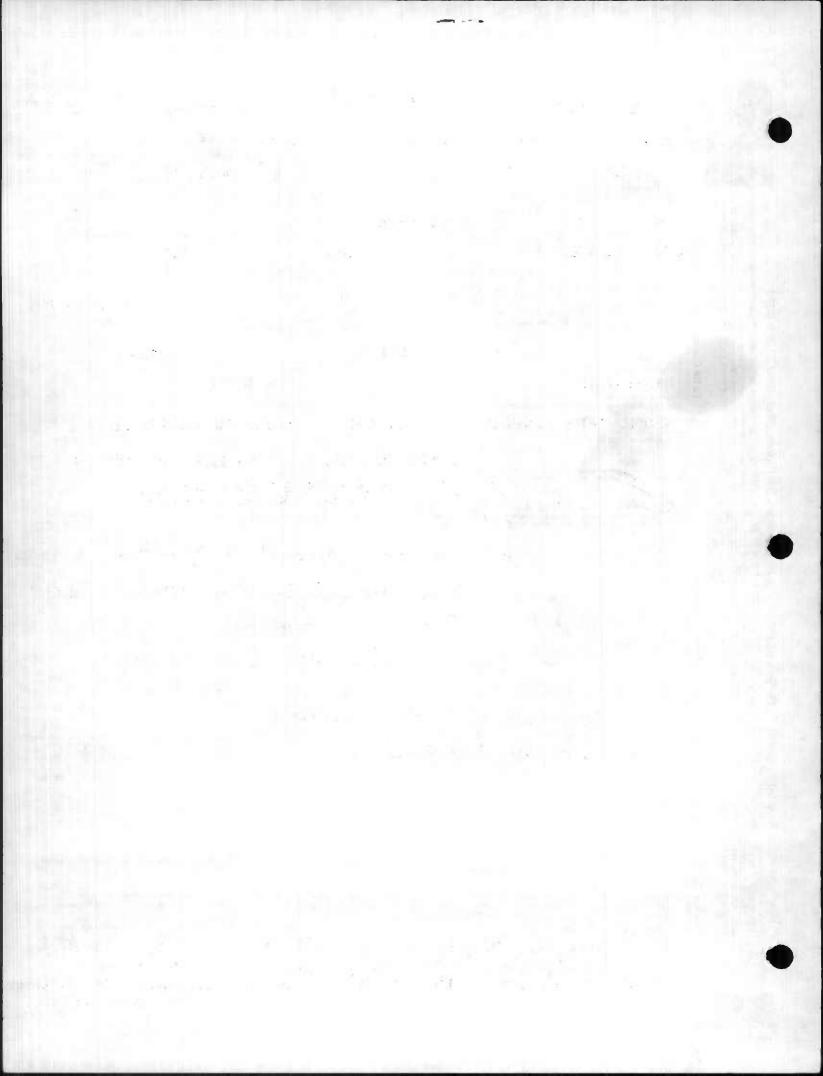
Registrar

resi of person

SEP 22

BELLNAILDO

31. Date filed (Month, Day, Year)



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middle, Last) 2. Data of Deeth 3. Tima of Death Month Dev Year **Physician** Eckert John Atwood 19,1998 SEPTEMBER 11:11 /Medical 4b. City, Town, or Location of Daeth 4c. County of Deeth 4a Facility Nema (If not institution, give street and number) Examiner Baltimore Saint Joseph Medical Center Towson 8. Data of Birth (Month, Day, Year) NOV • I 1935 9. Birthplace (State or Foreign Country) Maryland If Undar 1 Year If Undar 24 Hrs. 5. Social Sacurity Number 6. Sax 1 → M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Months Days Min. Hours 62 212-36-2251 Director Usual Rasidance of Dacedant 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show trsumstic event, the Medical Examiner must be notified at 10e. State 10b. County 10c. City, Town or Location 1 ☐ Yas 2 No Parkton Baltimore MD. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? IISA 16906 Flickerwood Rd. 21120 Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indien, Black, Whita, atc. 11. Marital Status 1 XYas 2 No Korean 1 Navar Marriad 2 Married 1 ☐ Yas 2 ② No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Collage (1-4or 5+) +2 Hygiene. Elamantary/Secondary (0-12) Baltimore Fire Dept. Captain 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be Katherine Adele Foreman Eckert Henry Karl 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16906 Flickerwood Rd. Parkton, MD. 21120 19a. Informant's Name/Ralationship (Type, Print) Mrs. Shirley J. Eckert/ Wife 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 9-24-98 Timonium, MD Dulaney Valley Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvica Licana 22. Nama and Address (Facility Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Part1. Enter the disections that caused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intarval Between Onsat and Death **Physician** /Medical Immediate Ceuse (Final DAY ACUTE MYOCARDIAL INFARCTION disaasa or conditio rasulting in deeth) Examiner Dua to (or as a consaquenca of): Examiner CORONARY ARTERY DISEASE YEARS physician end the burier frensit Sequentially list conditions, if eny, laading to immediata causa. Entar Undarlying Causa (Diseasa or Injury that initiated evants resulting in death) Last Dua to (or as a consaquanca of) Physician/Medical Dua to (or as a consequance of) 89 esn for signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 2 No 3 Probably 4 Unknown 1 Yes RETROPERITONEAL BLEED þ 24b. Ware autopsy findings available prior to Completed 24e. Wes en eutopsy GASTRO INTESTINAL BLEED peen completion of causa of deeth? has page 2 2 No 1 Tyes 1 Tas 2 N No certificata funeral director, Be 25. Was casa referred to medical examinar? 26. Placa of Daath (Check only one) Hospital: Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Ves 2 No 2 1 Inpatiant 2 □ ER/Outpetient 3 □ DOA this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? 28d. Dascribe how Injury occurred Certification: After 1 Neturel 2 ☐ Accident 5 Panding aftar death. Director: Aft 1 ☐ Yas 2 ☐ No Invastigation 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicida 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical

P.O. Box 68760, that the death certificate be Division of Vital Records, or Attending Physician: Hospital

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TIMOTHY LOW M.D. 31. Data filed (Month, Day, Year) SEP 2 2 1998

(Check only one)

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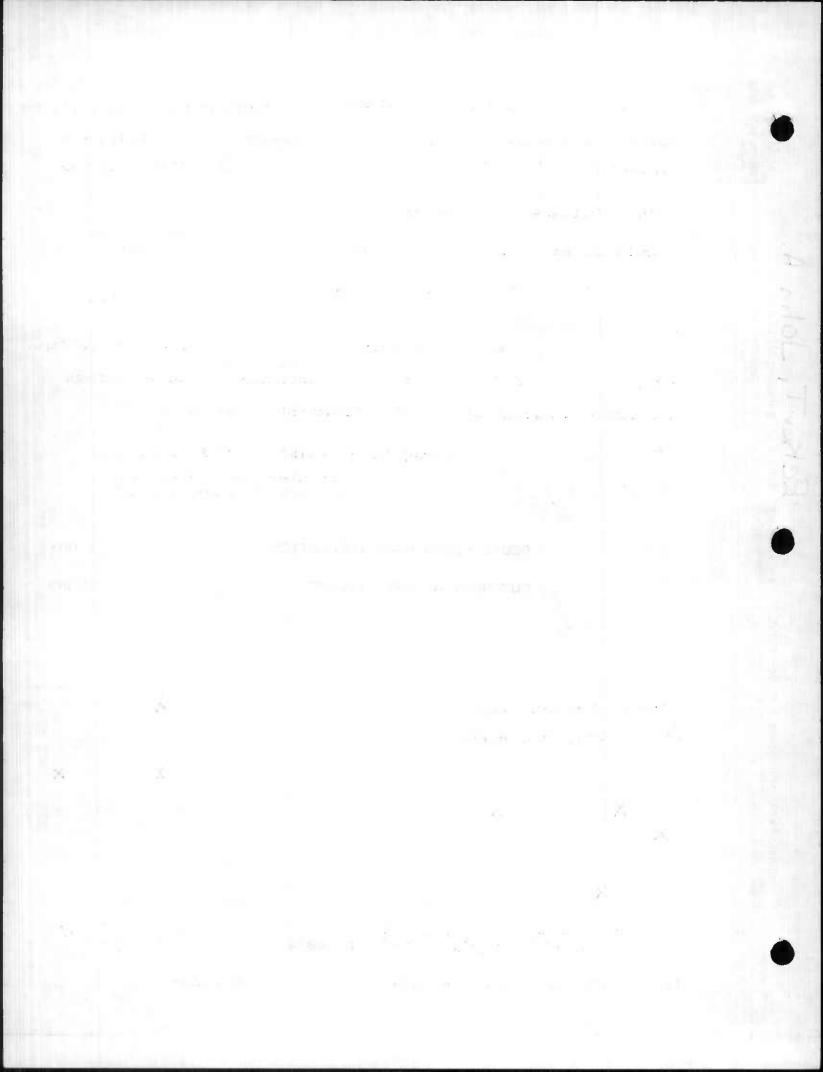
30. Nama and address of person who completed cause of death (Item 23e) (Type, Print)

YORK ROAD TOWSON MARYLAND 21204

29c. Licansa number 24034

29d. Date signed (Month, Day, Year,

Registrar

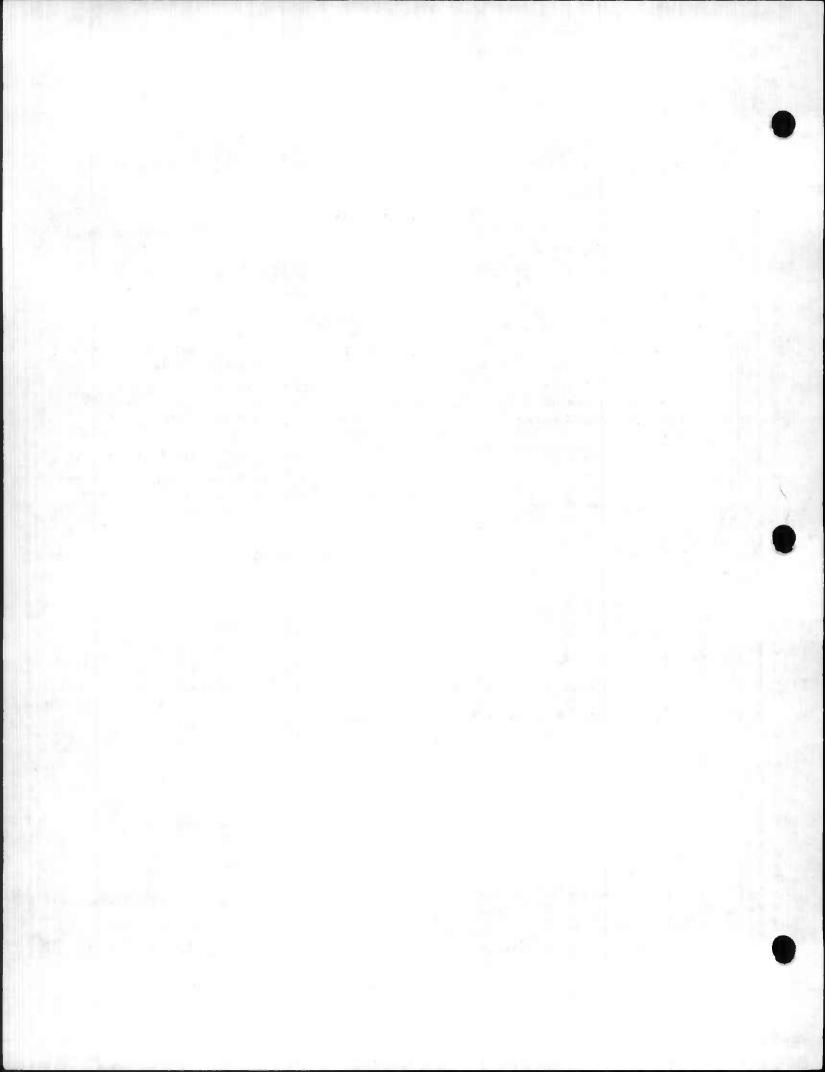


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sept. 20, 1998 Zenus Percy Fleming /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nema (If not institution, give street and number) Examiner 3705 Erdman Ave. **Baltimore** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Data of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** Days XXX 2 F 80 Yrs. 261-34-5793 Director March 12,1918 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits r than "naturel", or items 23s or 28s-f shore the Medical Examiner must be notified at n/a DCWes 2 No Director MD **Baltimore** 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 3705 Erdman Ave. 21213 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Ms. 2 □ No If Yes, Giva Year or Detes: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If them 27 te marked other than "naturel", or them any injury or other treumatic event, the same contact that any other treumatic event, the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact that the same contact the same contact that the same contact that the same contact that Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Windowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry y/Secondary (0-12) College (1-4or 5+) 4th Steel Worker Bethlehem Steel 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Andrew Fleming Mary Dotson 19a. Informant's Neme/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) John G. Fleming/son 3705 Erdman Ave. Balto., MD 21213 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 X Xurial 2 ☐ Cremation 3 ☐ Removel from State 9/25 4 ☐ Donation 5 ☐ Other (Specify) Baltimore National Baltimore, MD 21. Semuture of Funeral Service Licensee 22. Name and Address of Facility

James A. Morton & Sons Funeral Home 1701 Laurens St. Balto., MD 23a. Part. Enter the disease, or complications their caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, about princer that tailure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Finel disease or condition resulting in death) cerebro vascular accident Examiner Dua to (or as e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown arkinson's Disease Division of Vitai Records. þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes an eutopsy performed? Completed page 2 1 Yes 2 RNo 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Wes casa referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 70 1 ☐ Yes 2 ☑ No this After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident 5 Pending death. To the Hospital or Attendir within 24 hours efter death. To the Funeral Director: At complataly filled in by the fu 1 Yes 2 No investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, ferm, street, fectory, office building, atc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) september 31. Von Visoge 110211 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene Street, Baltimore mo apol Von Visa 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State SEP 2 2 1998 Registrar

DHMH 16 Rev 6/95

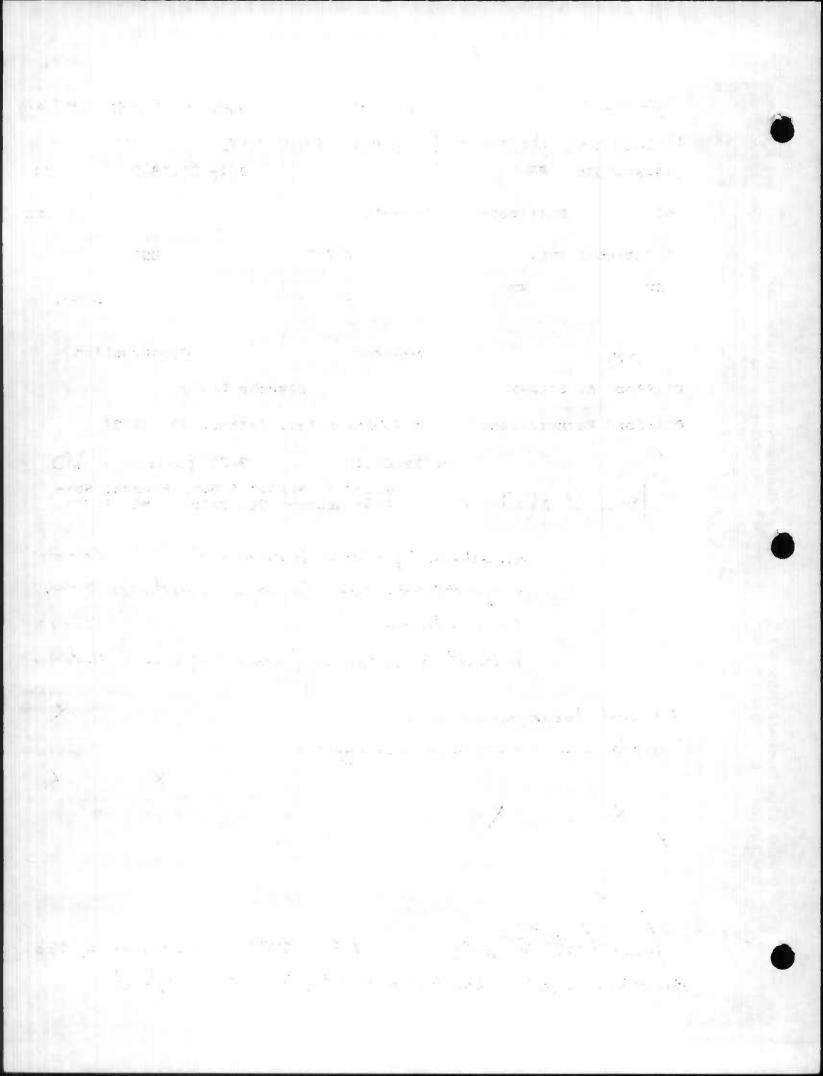


State of Maryland / Department of Health and Mental Hygiene 9 8

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Farmer Sylvester September 18, 1998 11:47 am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** Hopkins Daltimore Johns Haspita If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. July 21,1955 5. Social Security Number Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) 2□ F Months Days 43 216-66-3050 **Director** Usual Residence of Decadent with the Merylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at MD **Baltimore** Dunda1k 1 Yas 2 16 Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 Robinson Ave. 21222 USA Funeral 12. Was Decadent Ever in U.S. Armed Forcas? ★②Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Biack, Whita, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes XXNo Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If tem 27 is marked other than 'n any injury or other treumetic event, the Med bûce. Elementery/Secondery (0-12) College (1-4or 5+) Laborer Construction 12th 18. Mother's Name (First, Middle, Maiden Surnama) 17. Father's Nama (First, Middle, Last) Clifford A. Farmer Blanche Lewis 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Robinson Ave. Balto., MD Clifford Farmer/father 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 X Xurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donetion 5 □ Other (Specify) Holly Hills 9/22" 21. Some re of Funeral Service Licensee 22. Name and Address of Facility James A. Morton & Sons Funeral Home 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heert feliure. List only one ceuse on each line. 21217 Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disaese or condition resulting in deeth) /Medical 3 minutes **Examiner** Physician/Medical Examiner intracranial hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events brain eden rasulting In death) Last contusions 1 hemorrhas Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Munknown signed by pre umonia by 11 24a. Wes an eutopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? 188 2 No 25. Wes case referred to medical axaminar? Be 26. Piace of Death (Check only ona) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) To funeral 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Certification: i or Attending P s after death. i Director: After After 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No the 6 Could not be determined 3 Suicide 281. Location (Streat and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 ☐ Homicide 24 hours a Hospitai Cartifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and menner as stated.

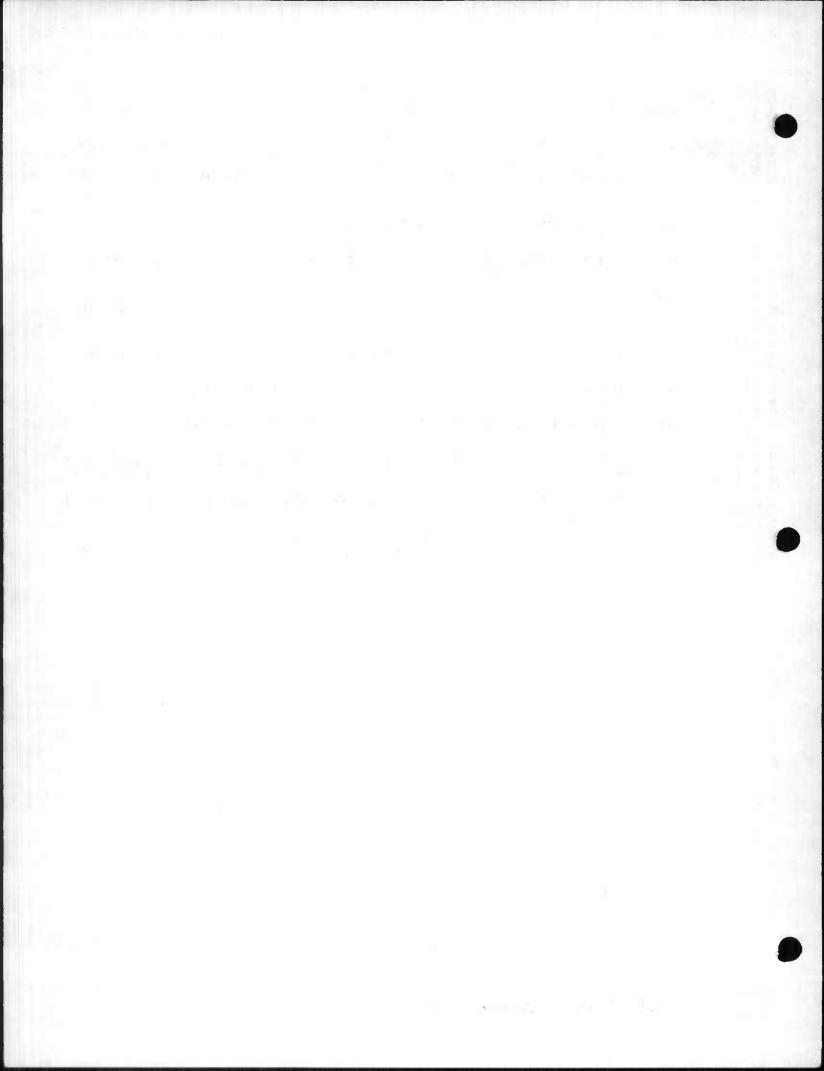
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi Medical one) 29b. Signature and title of pertifier 29c. License number 29d. Data signed (Month, Day, Year) RES-000 September 18, 1998 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Johns Hopkins Hospital, BAHimore, 31. Date filed (Month, Day, Year) 32 Registrat's Signature SEP 2 2 1998 Registrar

DHMH 16 Ray 6/95



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month 7 1998 **Physician** September Stanislaus FAZENBAKER ames /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Ceneral Hospital tallston 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 18 M 20 F Director 215 - 18 - 9283 **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location r than "natural", or hama 23a or 28a-f ahow the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD HARFORD FORESTHILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A.

14. Race · American Indian, 8806 BRANDY DRIVE 21050 death Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 1/Yes 2 | No if Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 11 Marital Status Bleck, Whita, atc. e filed within 72 hours after il Hygiens. other than "natural", or its 1 Never Married 2 Married 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) PAINTING GENERAL CONTRACTOR 1 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event bottos. 17. Father's Name (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Surname) Be P JAMES. FAJEN RAKER ANNA G. CONDY 0. 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) T. FAZENBAKER, SMUST 2088 BRANDY DR FOREST HILL 20c. Location - City or Town, State MARIE 20s. Method of Disposition 20b. Place of Disposition (Name of cematary, cremetory or other place) Deta SEPT. 21. 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removet from State 4 ☐ Donation 5 ☐ Other (Specify) GARDONS OF FAITH 1998 POSEDALE MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 18300 HARFORD ED. BALTIMORE, MD. 21234 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervst Between Onset and Death Physician /Medical Immediate Cause (Finet · Cardio vas cular disease or condition resulting in death) Examiner Due to (or as a consequence of): 3hr un thura ardiac a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be associate act disance DINOVIN Physician/Medical 8 Due to (or es a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à The law requires Completed 24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to discusa and completion of cause of death? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical 88 26. Place of Death (Check only ona) Hospital: 1 Danpatient 2 ER/Outpatient 3 DOA NO NO Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) Certification: To 1 ☐ Yes É 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Affer 1 De Naturat 5 Pending investigation death. 1 Yes 2 No 2 ☐ Accident a Hoapital or Attend 6.24 hours after death as Funeral Director; detay filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At homa, term, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledga, death occurred at tha time, data and place, and dua to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. Medical

Records, Division of Vital

O: Box 68760

Baltimore, Maryland 21215-0020

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Within 2 To the P

Registrar

29b. Signature and title of certified

(Check only one)

32 Registrar's Signatura

who completed cause of death (Item 23a) (Type, Print)

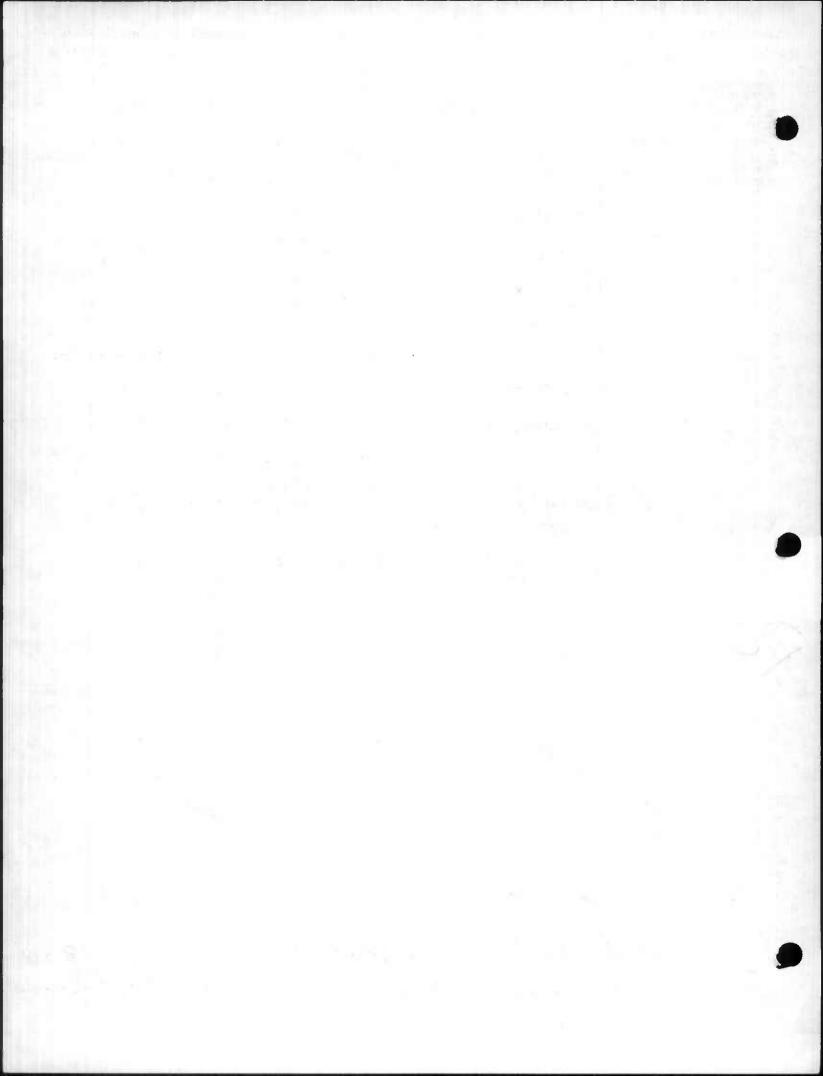
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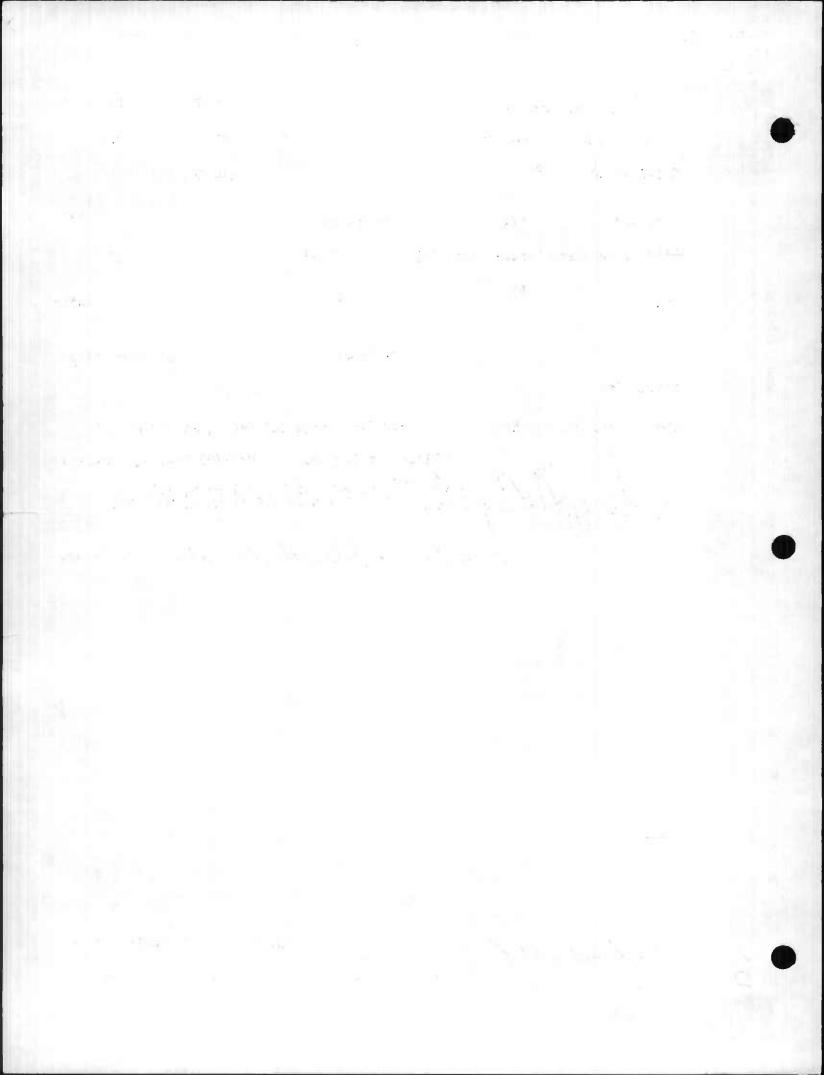
29d. Dala signed (Month, Day, Year)

SED: 8 9 6 32

State of Maryland / Department of Health and Mental Hygiene

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iner		a. Facility Name (fi	f not institution,	give street an	nd number)				4b. City, Town, o	r Location of De	ath 4c.	County of	of Death	
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	2	214 - 26 - 2	2193	6. Sex 1√□ M 2□		n yrs. last bir 73		der 1 Yaa hs Day:		n. (Month.	Birth Day, Year) 8,19	25	9. Birthpl Count PA	lace (Stata or Fo try)
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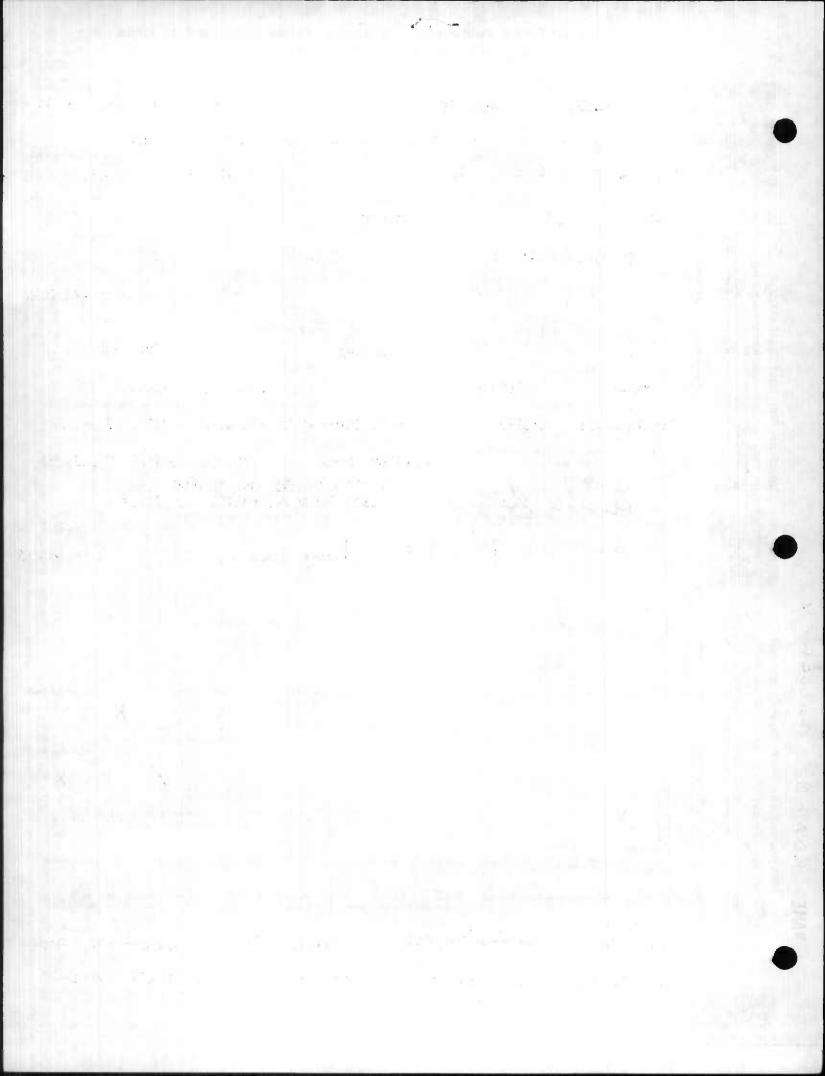


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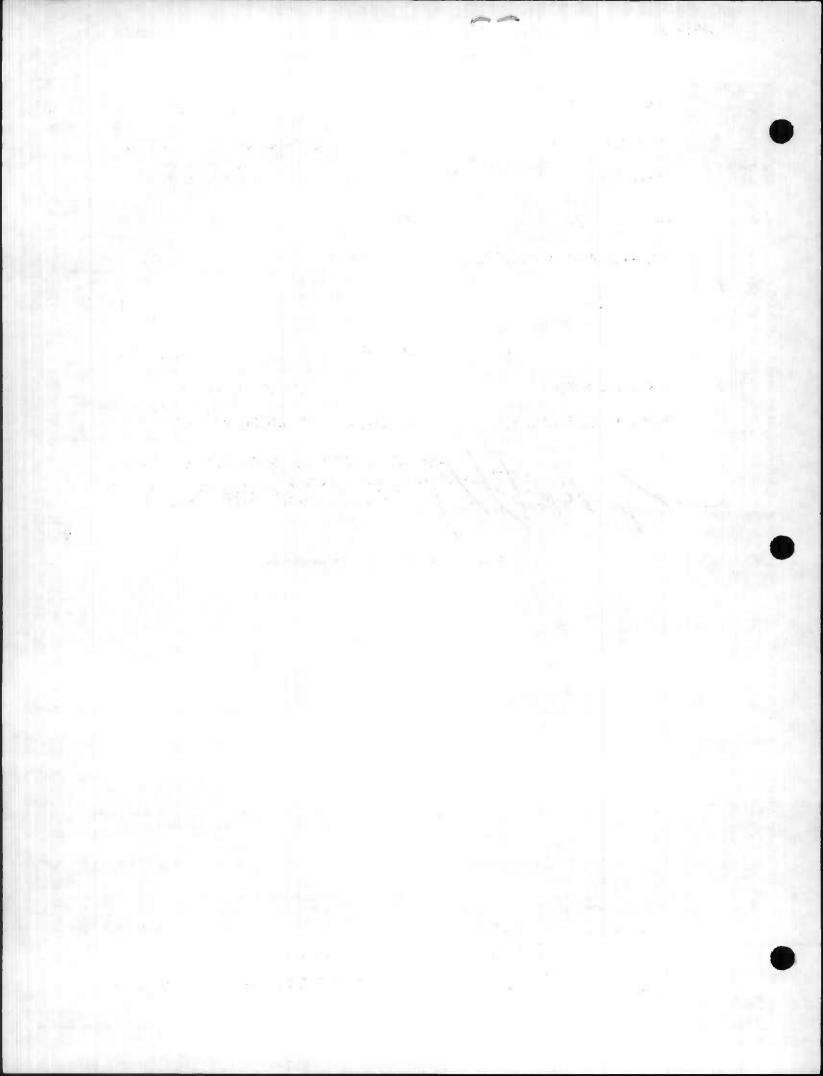
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ral tor	5. Social Security 215-78- Usuel Residence	Number 6. S 1042		e (In yrs. lest	birthday) Yrs.	If Under 1 Yee Months Deys	If Under 24 Hrs	8. Date of Bi	BALTO Profit Pey, Yeer) 1964		(State or Foreig
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O	15 WARR		RIVE APT. (	<u>^1</u>		21208			U.S.A		
by Funeral Director	11. Maritel Status		12. Was Decedent E Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates:	Ever in U,S.		/as Decedent of Yes, specify Cul ☐ Yes 2 X No	Hispenic Origin? (S ban, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	o- 14. Rec Blac	e - American Inck, White, etc.	dien,
leted	(Sp	15. Decedent's Ed	ducation	10	6a. Decede	ent's Usual Occur and of work done	pation during most of wo	orking		usiness/Industry	
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To Be	17. Father's Nem	e (First, Middle, Last) T GARDNER						me (First, Middle	o, <i>Maiden Sumen</i> FM∆N	10)	
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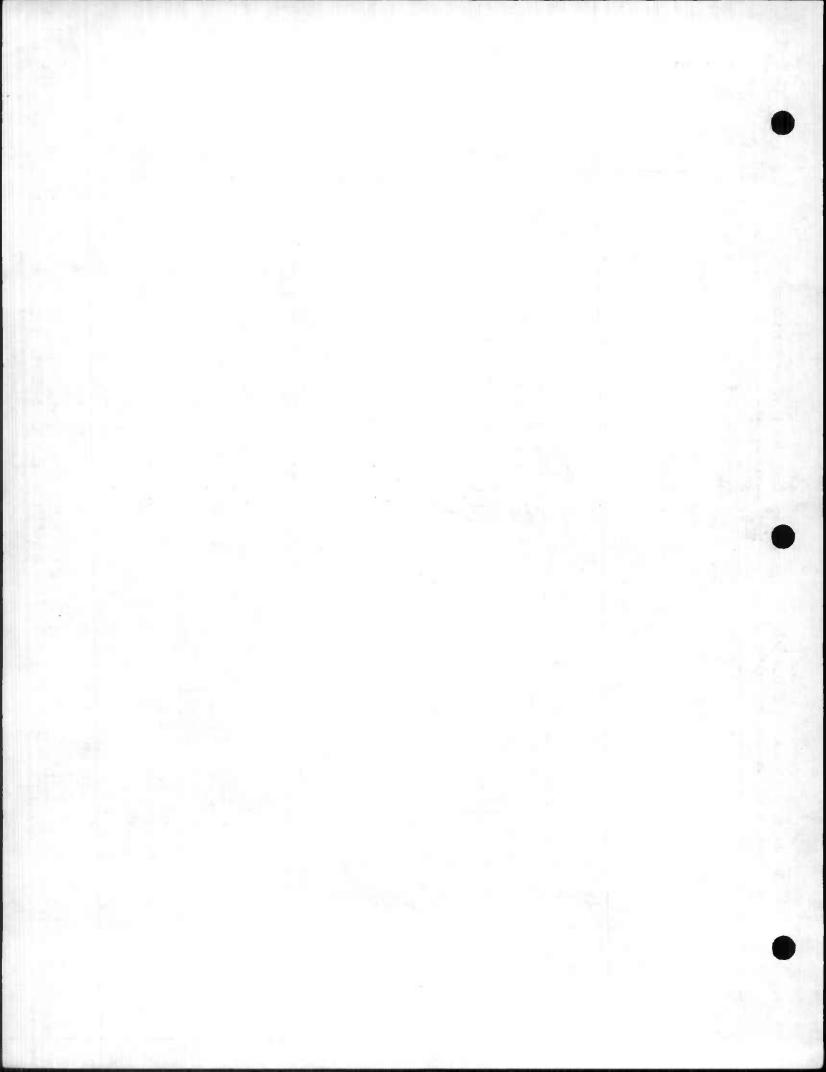
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Examine	An Problem Manney (Money Innellant	and the second second	ver) VE		4b. City, Town, or Lo BALTIMOR		4c. County	of Death			
Funeral Director	5. Social Security Number 216-84-8733	6. Sex 1⊠ M 2□ F	Age (In yrs. last birthday) 33 Yrs.	If Under 1 Yeer Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, May 12,		Birthplace (State Country)     MD	or Foreign		
anyland show	Usual Residence of Decedent 10a. State 10b. Coun	ty	10c. City, Town or Lo	ocation		10d. Inside City Limits 1 ⊠ Yes 2 □ No					
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic svent, its Medical Examinar must be notified at page.	15. Deceder (Specify only high Elementary/Secondary (0-12)	ent's Educetion rest grade completed)  College (1-4)	or 5+) (Give	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Carpet Cleaner  Briggs Carpet C							
Mental Hyg arked other atic svent,	Allen J. Gros	s, Sr.	18. Mothera Nem Jannie	Bennett	feiden Sumem	(e)	orean				
ond 2 shall hand 27 is m	19a. Informant's Name/Relation LaTonyer Benn				n Ave., B						
Pages 1 arment of Heam Int: If item ury or other	20e. Method of Disposition  1  Burlel 2  Cremation  4  Donation 5  Other	3 □Removel from Sta	20b. Place of Disp	osition (Neme of metory or other ple	ce)	Date 2	20c. Location -	City or Town, Stete			
Departi Departi Importu any Inji	21. Signature of Funeral Service 23a. Part1. Enter the disease,	0 ,	2	2. Name and Addre	ess of Facility Carroll F	uneral H	ome		5		
Physician /Medical Examiner the private physician physician and the physician and the physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physican physician physician physician physician physician physician p	shock, or heert feilure. Li  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying		nshot  Due to (or as a conse	quence of):	l of	Hear	d	Interval Bi	i Death		
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d by the stacher	Part II. Other eignificant condi	tions contributing to deat	h but not resulting in the u					of death?			
2 2 5						24a. Was ar perform		24b. Were autopsy evailable prior completion of of death?	rto		
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/Medical Examiner	Lea ne	reet and number)	ugh 145	o. City, Town, or Locat	ion of Death 4c. Cour	98 11-40F1
	5. Social Security Number 6. Sex	Knolls 7. Age (in yrs. last b	irthday) If Under 1 Year	Baltin If Under 24 Hrs. 8.	Date of Birth	A Bistolean (State of Facility
Funeral Director	216-20-1982 7	M 20 F 80	Yrs. Months Days		(Month, Day, Year)	9. Birtholace (State or Foreign Country) South Carolina
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4	30. Name and addrass of person who corr	pleted cause of death (Item 23a)		(0	11111	( ( 0
CARLO	ANIL UBEROS	44(C() FAL	15140 B	ALTO	MD 218	<b>}</b>
State Registrar	31. Date filed (Month, Day, Year) SEP 2 2 1998	preva /	G. Sparks	/		



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 1130 Month **Physician** Lelliand C GRANT /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Deeth Examiner Annaplis Eastport 1158 7. Age (In yrs. lest birthdey) H Undar 1 Yaar | If Under 24 Hrs. 8. Dete of Birth | Months | Deys | Hours | Min. | Month, Dey Year) cereance Anne Arundel 5. Sociel Security Number 9. Birthplece (Stete or Foreign Country) Tenns-Lvam 6 Sex **Funeral** 1 M 200 F 217-38-3782 Director Usuel Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside **Gity Limits** 7 is marked other than "natural", or items 23s or 28s-f shot traumatic event, the Med cal Exactinar must be not fied at 1 PYes 2 □ No Anne Krundel Annabolis Director MARYLAND 10e. Street end Number 10g. Citizen of What Country? Pages 1 end 2 should be filed within 72 hours effer death nant of Health and Mental Hygiena. If them 27 is marked other than "natural", or thems 23. Funeral Was Decedant Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - Amaricen Indien, Bleck, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Saltimore, Maryland 21215-0020 BLACK Specify: g 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast greda completed) Elementery/Secondary (0-12) College (1-4or 5+) Annapolis Rehab. NURSES 18. Mother's Neme (First, Middle, Meiden Surnema) 17. Fether's Neme (First, Middle, Last) UKn 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 2/40/ 19a. Informent's Neme/Relationship (Type, Print) Schooner Court Annapolis MD. Betty 805 Sohnson 20b. Place of Disposition (Name of cometery, crametory, or other piece)

HI/CREST McM. 20c. Location - City or Town, State 20a. Method of Disposition Important: If It any injury or c 1 Buriel 2 □ Cremetion 3 □ Removel from State permit. Page Departmant o 4 ☐ Donetion 5 ☐ Other (Specify) 1922 Forest DRIVE 21. Signeture of Funeral Service Licenses Annapolis 23a. Part1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or aspiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onsat and Daath **Physician** /Medical Immediate Ceuse (Finel Hypertensine Cardio vascular diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Examine present for sever physician and the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting In deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or as a consequence of) 80 usa ( Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown pulmary desiase 24b. Were autopsy findings eveileble prior to completion of cause of deeth? astuma 24e. Wes en eutopsy performed? Completed paga 2 1 Yes 2 No orteon theretos 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 I Nursing Home 5 Residence 6 ☐Other (Specify) 27. Manner of Death 28e. Dete of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 28b Time of 28c. Injury et Work? Certification: 5 Pending aftar death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Contifying Phyelcien: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) and menner as steted. 29e. Certifie Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) and menner stated. To the I within 2. To the I 29c. Licansa number 29d. Date signed (Month, Day, Year) 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

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32, Registrar's Signeture

HNNAPOLIS MD

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State

Registrar

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31. Dete filed (Month, Dey, Year)

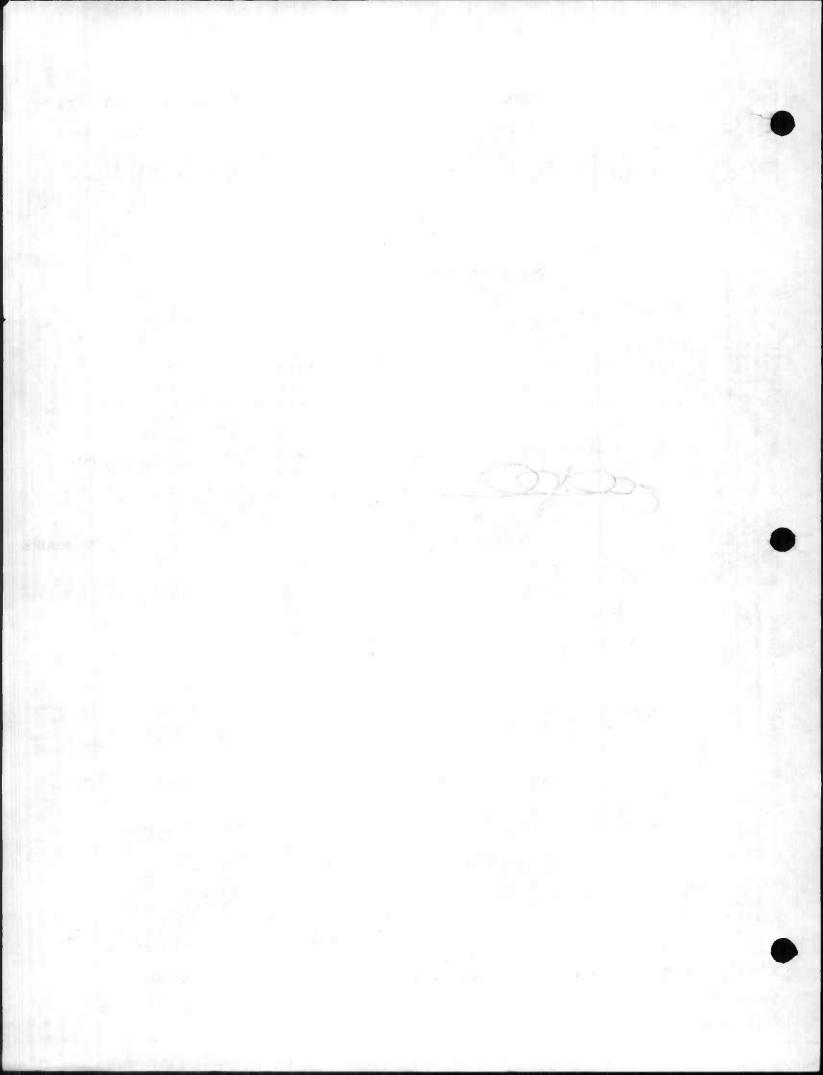
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State of Maryland / Department of Health and Mental Hygiene

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	Funeral Director	5. Social Security Number 6 223-22-3738 Usual Residence of Decedent	Sex 1 □ M 2 F 7.	Aga (In yrs. last b 75	Yrs.	If Under 1 Year Months Days		24 Hrs. 8. D Min. (A Se	8. Data of Birth (Month, Day, Year) 9. Birthplaca (Sountry) Sept. 29, 1922 Virgin			aca (Stete or Forei lry) ginia	ign
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	ter deeth with the Merylen term 23e or 28e-f show the ment be notified at Funeral Director	10e. Street and Number 245 Meadowvale Ro	oad		10f. Zip Code 21093					10g. Citizen of What Country? USA			
Maryland 21215-0020	by I	11. Meritel Status  1 Nevar Married 2 Married  3 Widowad 4 Divorced	12. Was Deceda Armed Force 1 Yes 2 If Yes, Give Year or Deta	s? No		Ves Decedent of I Yes, specify Cub		gin? (Specify ) , Puerto Rican	pecify Yes or No- b Rican, atc.)  14. Raca - Am Bleck, Whi			etc.	
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	01	La Malua Gud agara es bi baleoù mu	completed cause of	death (Item 23a	KType	TOW	SON,	MARYL	AND 2		10		
	State Registrar	31. Dete tiled (Month, Dey, Year) SEP 2 2 1998	32. Regi	strer's Signeture	1.	boars)	,						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Item#26 per FH G763 9/22/98 EW 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Day **Physician** Sept. 19, 1998 12:16 P.M Mary E. Gregory /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 3221 Chesley Ave Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 1, 1924 Birthpiace (State or Foreign Country) **Funeral** Days 1 M 2 F Months Hours 236-28-5450 74 Director Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 M Yes 2 □ No Directo Baltimore 288-1 Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? "natural", or items 23s or must be 1 West Conway Street 21201 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Meritel Stetus Bleck, White, etc. 1 Never Merried 2 Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: specify: White à 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiana. Elementary/Secondary (0-12) College (1-4or 5+) Maryland Cup Company Factory Worker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d 2 should be fi h and Mental H I is marked off Be Department of Health and Mental Important: if New 27 is mark-any injury or Parker Arrington Louise Anna Herman John 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley A. Schoenberger (Daughter) 3221 Chesley Ave Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremetion 3 □ Removel from State 9/22/98 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery Brooklyn Park, Md. 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility
McCully-Polyniak Funeral Home 130 E. Fort Ave Baltimore, Maryland 21230 Collina 23a. Pert Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Pancer Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last physician Box 68760 Physician/Medical for use as CANIM P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 2 No 3 Probably 4 Unknown signed b Records, by 24b. Were autopsy findings evailable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? page 5 t Yes Division of Vital e after death.

Brector: After this certificat in by the funeral director, p Be 25. Wes case referred to medicat examiner? 26. Place of Death (Check only one) Daughter's Residence 6 Mother (Specify) Residence Other: 4 Nursing Home Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 TYes 2 □ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Funeral D Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 24 To the I 29b. Signature

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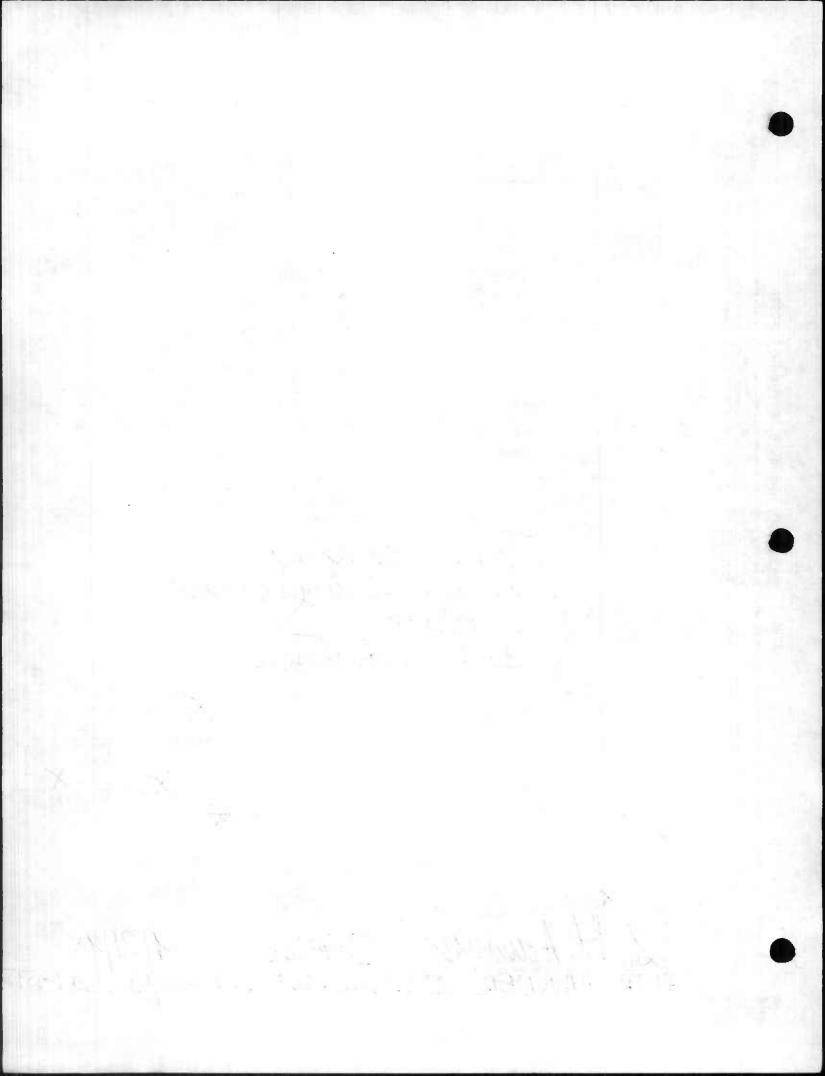
State Registrar SEP 2 2

32. Registrar's Signature

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S. Grane Steet, Ballimore

(Item 23a) (Type, Print)

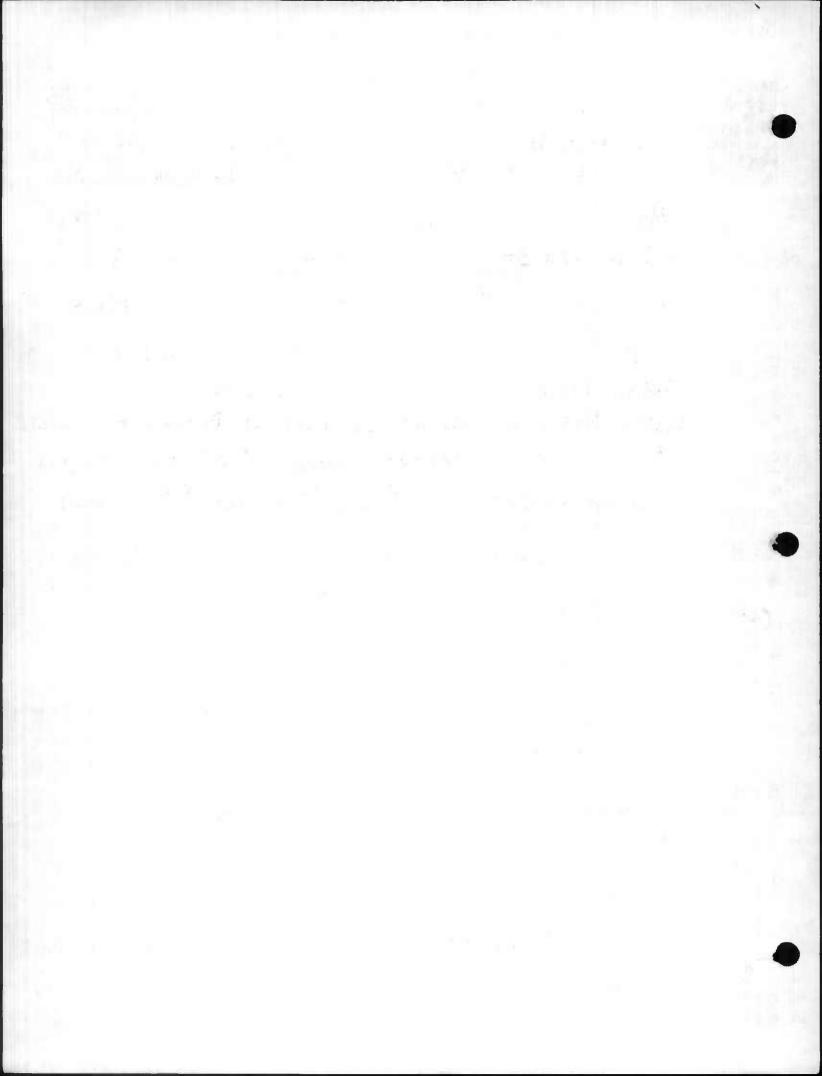


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death 6 PM **Physician** Month ELIZABETH HACWOOD SEMPLEMOUS 19 1998 /Medical Facility Name (If not Institution, give street end number) 4b City Town or Location of Death 4c. County of Death Examiner Baltimore Md If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funerai** 1 M 2 F Deys Hours 80 216-18-094 Yrs. Director Nov Usual Residence of Decedent the Maryland or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md Director 1 Yes 2 No Baltimore 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? TRAFE DE D 833 71223 Completed by Funeral daath 12. Was Decedenf Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritel Status "natural", or item filed within 72 hours after 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Black Specify: 3 DWidowed 4 □ Divorced Specify: traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other than Elementery/Secondary (0-12) College (1-4or 5+) Hygiana. HouseKeeper 12 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pagas 1 and 2 should be I ANDrew GrEEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rure! Route Number, City or Town, State, Zip Code) Baltmore, Md 2
20c. Location - City or Town, State Mason Haalth 8 Ellamount Daughter LEANNA 1040 Item 27 20a. Method of Disposition 20b. Plece of Disposition (Name of cometery, crematory or other place) Defe 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State = 5 Department of important: if any injury or once. Baltmore, Natural
22. Name and Address of Facility Baltmore, Md 4 Donetion 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Carroll FUNETAL Home 1712 W. North AVE Baltimore 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between **Physician** /Medical Immediate Cause (Final MINNITES · ACURE MY UCONDIAL INFARCTION disease or condition resulting in death) Examiner Physician/Medical Examiner remns MTMIDSCLENOTIC CONDIDVASCULAN DISLAGE Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of). P.O. Box 68760 The law requires that the death cartificate be Due to (or as a consequence of): is cartificata has been signed by the a director, paga 2 should be datached f Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown EMPIRYSEMA Records, ò 24b. Were eutopsy findings available prior to completion of ceuse of deeth? Be Completed 24a. Was en eutopsy performed? CIMMING BOMMANL SWILLDING 2 NO 1 Yes 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: 25. Was cese referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home Standardence 6 Other (Specify) Hospital: 1 ☐ Inpafient 2 ☐ ER/Outpetlent 3 ☐ DOA 1 Yes 2 No P in by the funaral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28c. injury ef Work? 28d. Describe how injury occurred Aftar Division 5 Pending investigation 1 Tes 2 Accident aftar death 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Af home, farm, sfreet, factory, office building, etc. (Specify) 4 Homicide Hospital To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical complataly 29b. Signeture end fitte of certifier 29c. License number 29d. Date signed (Month, Day, Year) D15135 SEARMBIN 20, 1996 ess of person who completed ceuse of death (Item 23e) (Type, Print) BMIMULLI 5601 LOUS MAN OLVD SCUTT MD STE 572 31. Date filed (Month, Day, Year) SEP 2 2 1998 32 Registrar's Signature / State SEP Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** 4e. Facility Name (If not institution, give street and number) 058 4b. City, Town, or Location of Deeth /Medical 4c. County of Death Examiner Sever Road neenstown (HOME 5 If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplece (State or Foreign Country) **Funeral** Months Deys 100 M 2□ F Hours 218-22-1896 Yrs. 0 Director Jan NY Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show I is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Maryland Director (0, 1210 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 559 Road MANO Funeral 12. Wes Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 11 Maritel Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American indien, Bleck, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 No Specify Specify: American by 3 Widowed 4 □ Divorced Completed 16h. Kind of Business Industry House 6. Lokec froms 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withit Department of Health and Mentel Hygiene. Important # 11 marked other than any injury or other traument. Elementary/Secondary (0-12) College (1-4or 5+) State of Mur 901 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumame) Be Roudluphus 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21144 Sharon Hall-Fleming wood xiva Screro, Mdtates Doughter (VOC Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) 9/21 Rest 12+ 3-car 3. 21. Signeture of Funeral Servica Licensee 22 Neme end Address of Fecility Place 7 uneral loydon. Baltimore, Manglad 23a. Part1. Enter the disease, or complications that shock, or hear failure. List only one cause on 1300 Eutav one that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical arcinon Examiner Due to (or es e consequence of): Examiner signed by the attending physician and d be detached for use as the burier-gransit requires that the death certificate becaused Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Physician/Medicai Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by should I 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of death? aw W page 2 The cartificate 20No 1 Tes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Day Year) Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Naturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

P.O. Box 68760, Division of Vital Records,

State

Medical

29e. Certifier

(Check only one)

29b. Signature and title of certifier

31. Dete filed (Month, Day,

Registrar

who who completed cause of deeth (Item 23a) (Type-Print) 0

Year) 22

SEP

32. Registrer's Signeture

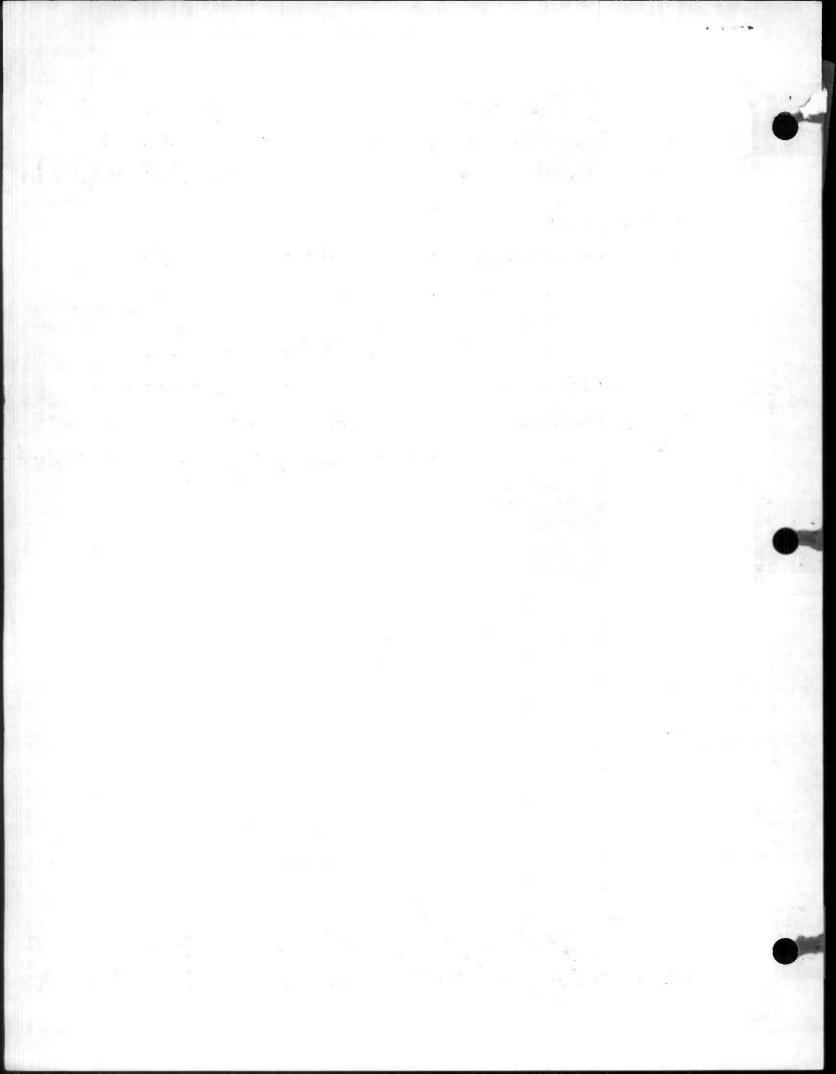
29c. License number

\*\*Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) end menner steted.

29d. Dete signed (Month, Day, Year)

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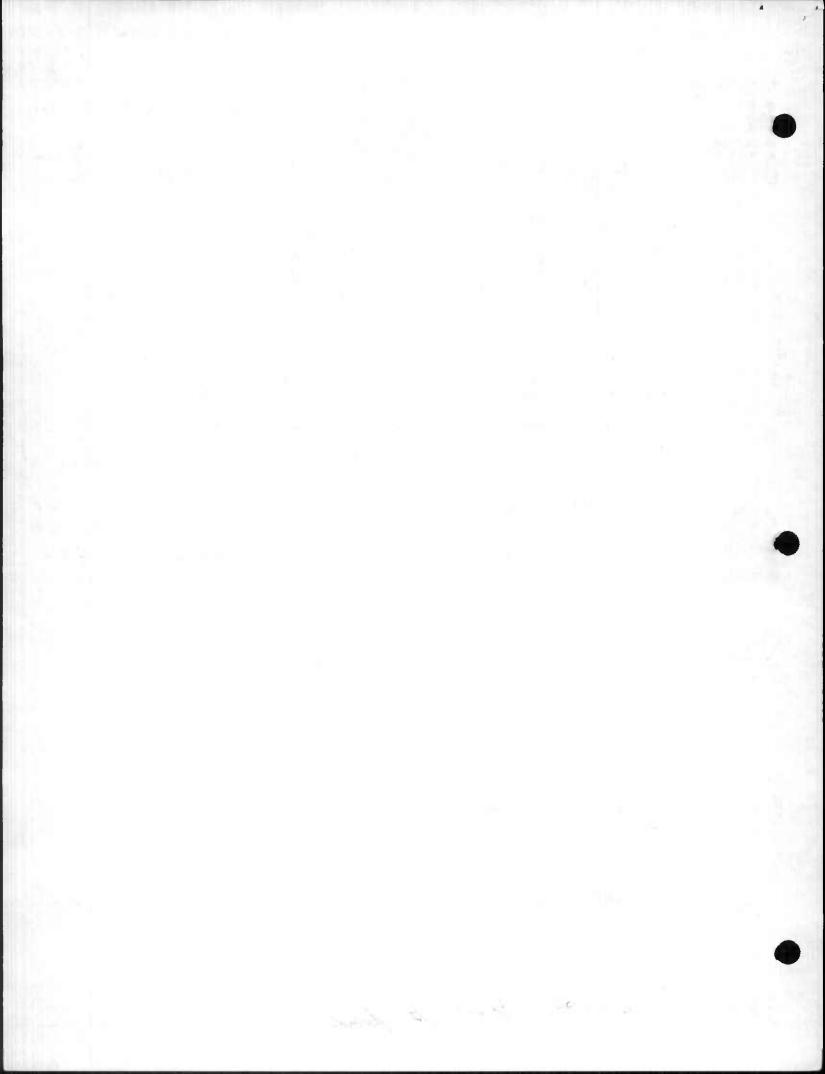
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State of Maryland / Department of Health and Mental Hygiene 9 8 28872

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	Funeral		5. Social Security Number 6. Sec	7. Age (in yrs.	2 C Month	der 1 Year   If Under 24 Hrs is Days Hours Min		Xear)	9. Birthpiace (State or Foreign Country)
	Director		Usual Residence of Decedent	2	Yrs.		helc. 1	3,1909	Pennsylvania
	yland		10a. Stete 10b. County	10c. City	y, Town or Location				10d. Inside City Limits
	Se-fa	Director	Md. Baltin	TORE PO	rekville				1 □ Yes 2 No
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Baitimore,	00		20a. Method of Disposition 1 Disposition 3 □ R	^	lece of Disposition (fi emetery, cremetory of	lame of r other plece)	SLAY. 19	20c. Location - C	City or Town, State
Him			4 Donation 5 Other (Specify)  21. Signeture of Furferal Service License	MB	reland M.	and Address of Facility	11998 11	alkvil	L. Maryland
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	within 2 To the	Me	29b. Signeture end title of certifier		1	29c. License number	2	9d. Date signed	(Month, Day, Year)
				VA		1041100	+	Sept.	18,1998
	15		30 Name and eddress of person who co	moleted cause of deeth (Item	23a) (Type, Print)	NSBA NA	21281	1	
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or Items	by Funeral Director	11. Marital Status  1 Never Marriad 2 Married 3 Widowed 4 Divorced	12. Was Decedanf Ever in L Armed Forces? 1  Yes 2  No If Yes, Give Yaar or Datas:	If Yas, s	cedent of Hispanic Origin? (pecify Cuban, Maxicen, Pue	Specify Yes or No rto Rican, atc.)	14. Race Black Specify:	e-American Indian, k, White, etc.
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Yes 2 No dance 6 Othe now Injury occurre Street and Number vn, State) cause(s) and mar date and place, a	onset and Death  4 9 RS  tribute to the cause of dea 3 Probably 4 Unkn  24b. Were autopsy finding available prior to complation of cause of death?  1 Yes 2 No  or (Specify)  ed  or or Rural Route Number,  nner as stated.  nd due to the cause(s)



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Desth 3. Tima of Death **Physician** 16:30 A.M. September 1993 Estie Virginia Hoffman /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Baltimore Kosedale Center If Undar 1 Yaar if Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Dec. 15,1916 6 Sax 5. Social Security Numbal 7. Aga (In yrs. last birthday) Birthpiace (State or Foreign Country) **Funeral** Days Hours Min 1 M 287 F 215-26-6324 Yrs. 81 Director West Virginia Usual Rasidance of Decedant 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Manylan nent of Health and Mental Hygiena. Inter of Health and Mental Hygiena. Inter if item 27 is marked other than "natural", or items 23a or 28a-f ahow any or other traumetic avent, the Modical Examiner must be notified at 1 Yas X No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 5608 Daybreak Terrace 21206 Funeral USA 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐XNo If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amaricen Indian. 11. Maritai Status Black, Whita, atc. 1 ☐ Navar Married 2 ☑ Married 1 Yas 2 No Specify: Specify: White λq 3 Widowed 4 Divorced Completed 16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Eiamantary/Secondary (0-12) Coliaga (1-4or 5+) SperryRand Remington 12th Secretary 18. Mothar's Nama (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middla, Last) Elihu King Loughry Millie Ellen Polling 19b. Mailing Addrass (Straet and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Raiationship (Type, Print) 5608 Daybreak Terrace 20b. Place of Disposition (Name of cemetery, crematory or other place) George Hoffman / husband Baltimore MD. any Injury or other 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1X Burial 2 Cramation 3 Ramovai from Stata Gardens of Faith Cemetery9/22/98 Depertment Inportant: If Rossville 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility Connelly Funeral Home of Essex 23a. Part1. In ar tha disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest. Approximata Intarval Batwaan Onsat and Death **Physician** /Medicai Immediata Causa (Finai Sepsis Week disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of): a weeks Examiner Neutropenia Sequantially list conditions, if any, laading to immadiata ceusa. Entar Underlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last Dua to (or as a consequance of): and Chemotherapy Dua to (or as a consequence of): Colon Carcinoma Physician/M Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by t 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 Yas 2 PNo 1 TYAS 2 NO certificata director, 25. Was casa rafarrad to medical Be 26. Piaca of Daath (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 2 1 Yas 2 No funeral 28a. Data of injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. injury at Work? 1 Natural 5 Panding invastigation 1 Yas 2 Accidant 6 Could not be datamined 3 Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifian complataly

Box 68760 Division of Vital Records, P.O. or Attending Physician: eftar death. Diractor: After this certifica Hospital
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 Funeral

HOFFMAN, Estic

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State Registrar

To the Within 2

31. Data filad (Month, Day, Year) SEP 2 2 1998

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29b. Signatura and titla of certifiar

30. Nama and addrass of person who com

Dr. Herman Junker

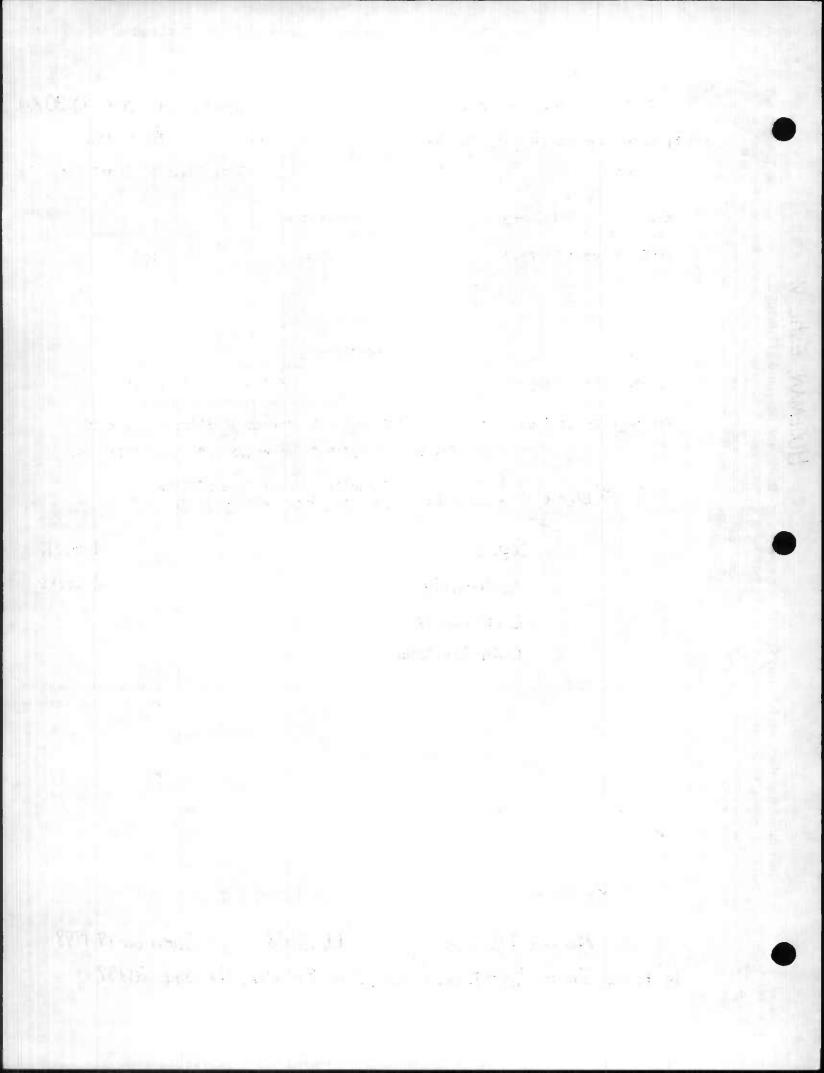
usa of death (Itam 23a) (Type, Print)

Drive, Baltimore, Maryland 600 Franklin 32. Ragistrar's Signatura

29c. Licansa number

29d. Data signed (Month, Day, Year)

September 19, 1998



Doctor Mark Himmelheber 9000 Franklin Square Drive Ballimore Maryland 21237

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Registrar

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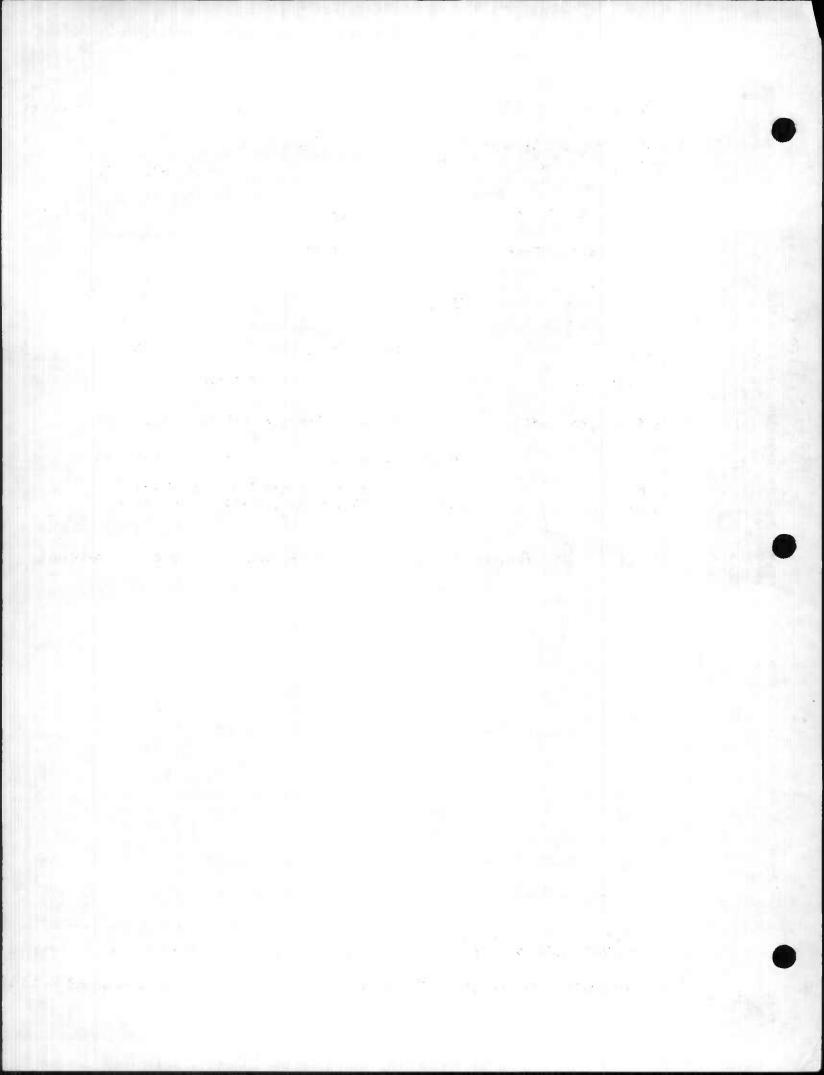
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30. Name and addrass of person who complated cause of death (Itam 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death C. Month **Physician** Rebecca Hemmingway : 30 AM 201 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Turch Home HOSPITA altimore If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country) Days 212-24-9395 1□M 20 F Yrs. **Director** 11-1906 Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits filed within 72 hours after death with the Mary 1 Yes 2 No Director Ma NA 28a-1 Daltimore the Medical Examiner must be notifly 10e. Street end Number 10f. Zlp Code 10g. Citizen of What Country? ò 21229 ranklin 238 3600 , S. H Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Raca - American Indian. Biack, White, etc. 1 Never Married 2 Married 6 1 ☐ Yes 2 No Specify Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decadent's Education (Specify only highest grede completed) 16a. Decadent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elamantary/Secondary (0-12) College (1-4or 5+) Home gan grade NA Lay Car 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) outes Lo James 19a. Informant's Name/Ralationship (Type, Print) -Son 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Code) important: if item 27 is any injury or other tra snos. Hemmingway Ly Custa

20b. Placa of Disposition (Name of paradam, crematory or other paradam, crematory or other paradam) Gaster brook Dr mest torseheads New York 20a. Method of Disposition Date 20c. Location - City or Town, State cemetary, crematory or other place) 1 ☑ Burlai 2 ☐ Cremation 3 ☐ Removal from State Memorial Park 9-24-98 Donation 5 Other (Specify) 22. Name end Address of Facility yarch F. H. West Md 21215 4300 Wabash Avenue 23a. Furt1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Due to (or es a consequance of): Physician/Medical Examiner neummun The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last ettending physiciar and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 3 Probably 4 Unknown 1 Yes 2 No ementia by Completed 24b. Ware autopsy findings available prior to 24e. Wes en autopsy performed? completion of cause of death? certificate has 2 No 1 Tes 1 ☐ Yes 2 No Physician: Certification: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2N No After this 27. Mannar of Death 28b. Time of 28d. Describe how injury occurred or Attending Natural 2 Accident 5 Pending investigation in 24 hours efter death.

the Funeral Director: After the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the funeral new the fune 1 ☐ Yes 2 ☐ No 6 Could not be datamined 3 ☐ Sulcide 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edicai Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es stated.

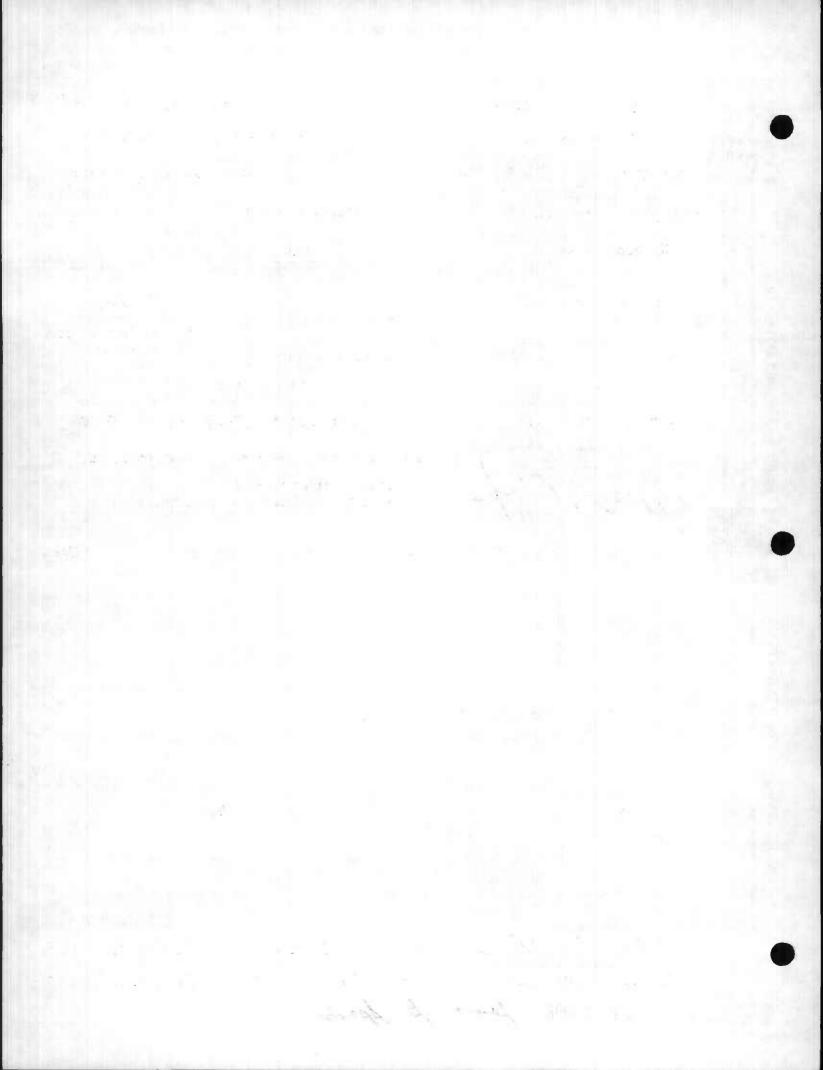
Medical Examinar: On the basis of axemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) al person who complated cause of death (Item 23a) (Type, Print) BAUTIMONES 100 31. Date file 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene

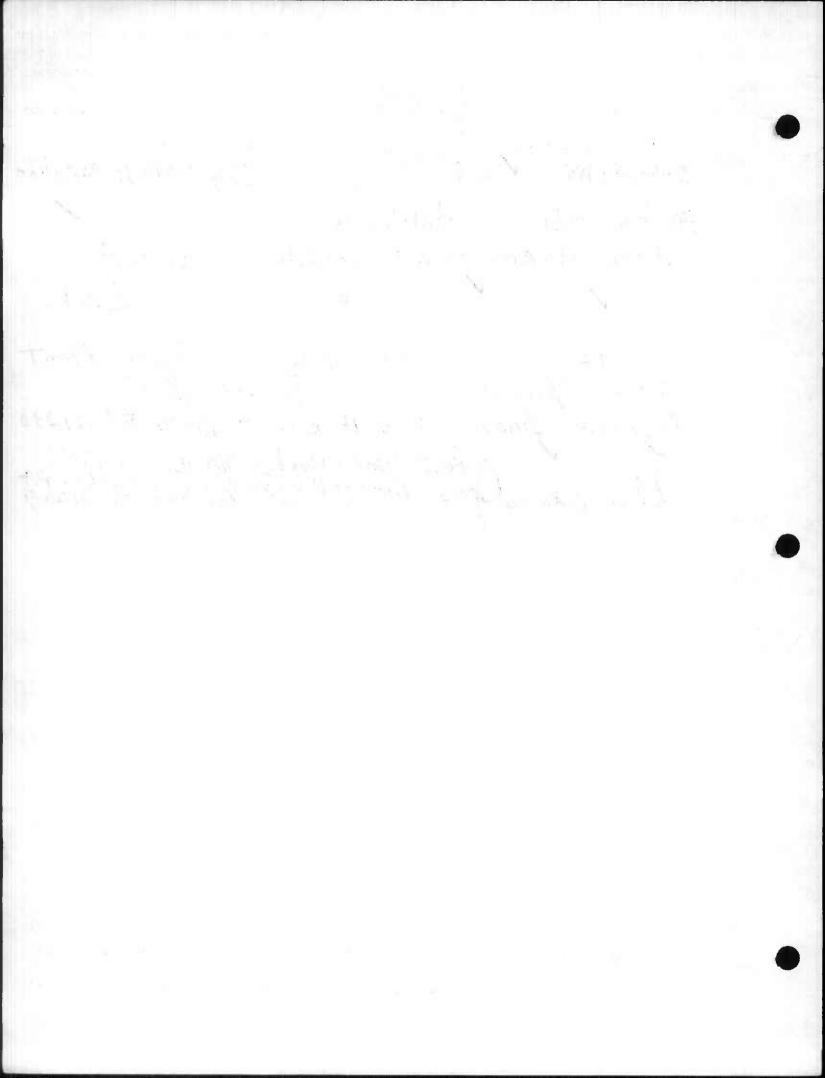
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	Physician · /Medicai	Decedent's Name (First,  THELMA		HORST							2. Dete of D Month Sept.	17, 199		3. Time of Death 5:00 AM
	Examiner	4a Fecility Name (If not ins			iumber)						ocation of Dea re Co.		ltimo	ore
01.	Funeral Director	5. Social Security Number 218-09-6618		ex □M 2√√ F	7. Age (lir	yrs. lest birthday Yrs.	) If Unde Months	Days	If Under Hours	Min.	8. Date of B (Month, D	irth Pay, Yeer) 9,1920		plece (Stete or Foreign cyland
	Maryland of show	Usuel Residence of Deceder 10e. State 10b. C Maryland B		ore	10	c. City, Town or I		ltim	ore C	ount	y			10d. Inside City Limits 1 ☐ Yes ¾(又No
	with the a or 28s	10e. Street end Number 1823 Hanford	Rd				10f. Zi	p Code	21237			10g. Citizen of What Country? USA		
20	d 2 should be filed within 72 hours efter death with the Maryland than Mental Hygiene.  7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinations to profit at To Be Completed by Funeral Director	11. Merital Status 1 □ Never Married 2 □	Married	12. Was De Armed F 1 Tyes If Yes, G Year or	Forces? S XX No Give	r in U,S. 13		edent of H ecify Cuba		gin? (Sp i, Puerto	ecify Yes or N Rican, etc.)		ck, White,	
00-612	be filed within 72 hour tal Hygiene. I other than "natural' svent, the Medical Exvent, the Medical Ex	15. Der (Specify only) Elementery/Secondary (0	edent's Ed highest gre	lucation de completed		(Giv	edent's Usu e kind of w DO NOT u	ork done	during mos	t of work	ing	Balto.	Business/Industry  County Board	
Baitimore, Maryland 21215-0020	merked other than	12 yrs. 17. Fether's Neme (First, M Frank Horst	iddle, Last)	N/A		Ca	feter	ia W		er's Nam	e (First, Middl Yost	of Educ le, Maiden Sumer		1
Mary	CHNE	19a. Informant's Neme/Rel Randy C. Hor					Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 119 Willowdale Ave. Baltimore, Md. 21206							
Imore,	Pages I nent of He ant: If Nen ary or oth	20a. Method of Disposition  20a. Method of Disposition  1X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Placa of Disposition (Neme of cemetery, cremetory or other placa)  Gardens of Faith  9-21-98  Baltimore,											- City or T	own, Stete
pair	Departit Departit Importa any inju	21. Signeture of Funeral Se	f	unera	1 Ho		e, Md. 2	1236						
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Į.	/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)		a		NARY to (or es e cons			RY	D	15EAS	E		YEARS
3	rand al-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury c.												
BOX 66/60,	rentificate be executed right and seas the bunal-transit													
. D		Part II. Other significant conditions contributing to death but not resulting in the underlying cause RHEUMATOID ARTHRITIS							en in Pert I		23b. Did tobacco use contribute to the cause			to the cause of death?
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ecords	The law requires that the death cate bas been signed by the atterpage 2 should be detached for Completed by Physicial											es en eutopsy formed?	9	Vere eutopsy findings veilable prior to ompletion of cause of deeth?
פופ	n: The licate h		adias!						00 5	10		Yes 2 No	1	☐ Yes 2☐ No
DIVISION OF VITAL RECORDS,	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attercompletely filled in by the luneral director, page 2 should be detached for Medical Certification: To Be Completed by Physicial	1 ☐ Yes 2 ☑ No	edical rending	28e. Det	Inpatient of Injury onth, Dey Ye	2 ER/Outpati		28c. Inju	ner: 4□ Nu	irsing Ho		sidenca 6 Oti e how injury occu		ity)
DIVISIO	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the luners. Medical Certification:	2 Accident 3 Suicide 6 C 4 Homloide	At home, farm, s Specify)			165 2	140	28f. Location City or T	(Street end Num own, Stete)	ber or Rui	rel Route Number,			
	Hospi 24 hours Funer pletely fill	29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)												
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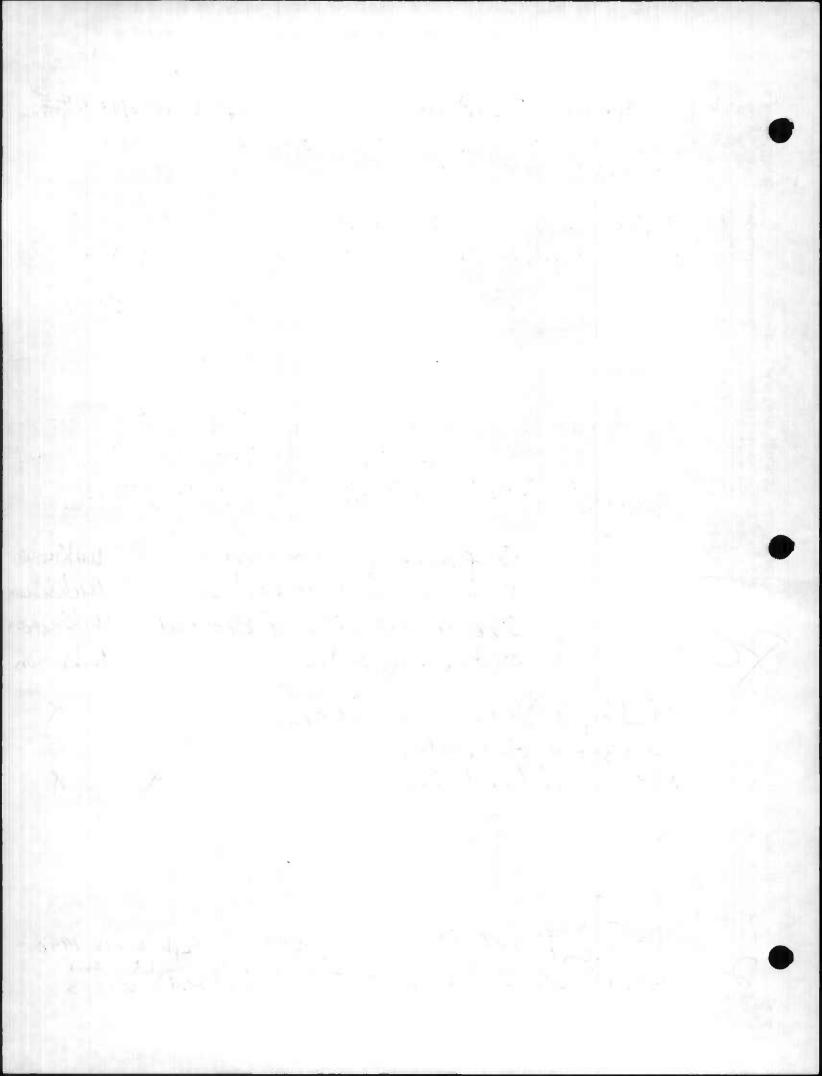
State of Maryland / Department of Health and Mental Hygiene 98 28878

					Cer	tificate	of Death		Reg. No.		
		33	1. Decedent's Name (First, Middle, Last)					2. Data of De	ath		3. Time of Death
	Physici /Medi		DOROTHY LEWIS	JACKSON				Sept.	22, 19	Year 93	3.00 am
	Examir		4a. Facility Name (If not Institution, giva				4b. City, Tow	n, or Location of Death	-		
			3010 Huron Str	eet			Baltin	nore	N/A		
	Funeral Director		5. Social Security Number 6. Sax 2 44 68 98 1 1 Usual Residence of Decedent	7. Age (In urs.	last birthday) Yrs.	If Under 1 Y Months D	aar If Undar 2 ays Hours	4 Hrs. 8. Data of Birt Min. Month, Da	79943	9. Birthplac	ARUINA
	show ed.st	0	10a. State 10b. County A	10c. C	y, Town or Loc		0			10d	l. insida City Limits
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20	iges I and 2 should be lied within 72 hours arrar death with the maryland at of Heelin and Mental Hygiene.  And Heelin 21 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examiner must be notified at	y Funeral Director	1 Never Married 25 Married	I2. Was Dacedant Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Giva	IT	Vas Decedent Yes, specify	Cuban, Maxican,	in? (Specify Yas or No Puarto Rican, etc.)	14. Nac Blac Specify	e - American ck, White, etc	Indian,
2-00	natural',	eted by	3 Widowed 4 Tolvorced  15. Decedent's Educ (Specify only highest grade	Year or Dates:	16a. Deced	ent's Usual O	ccupation one during most	of working	16b. Kind of Bu	211	stry
21215-0020	e med within /z hours il Hygiene. other than "natural", vent, tre Med cal Exe	Completed	Elemantary/Secondary (0-12)	Collaga (1-4or 5+)	Da D	ONOTUSE I	atired)	o. Womany	Tohas	100	Plant
and	Mental Hy Mental Hy arked other atic event,	Be	17. Father's Name (First, Middle, Last)	now			18. Mother	SSIE	Malden Sumam	(e)	
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	of Heelth end of Heelth end of Heelth end of Item 27 is m		20a. Method of Disposition		Place of Dispos			Date	20c. Location -	City or Town	1, State
	ant ar		1 Deurial 2 □ Cremation 3 DA 4 □ Donation 5 □ Othar (Specify) 21. Signature/of Funeral Service Ucense	Re.	st /	Aver	Cemet	ery 9/28	W1/5	on Y	D.C.
Ва	Departr Importu any inje		Plone after	mo fore		ARSh	AT) ly	on Ave.	BAHTO	ma	21229
	hysician		23a. Part1. Entar tha disaasa, or complic shock, or heart failure. List only on	cations that caused the daa e cause on each line.	th. Do not ente	or the mode of	dying, such as o	ardiac or raspiratory a	rest,	In	opproximate interval Between Onset and Death
	/Medical Examiner	ler	Immediata Cause (Final disease or condition rasulting in death)		O COYC		λ		-	(	smonths
2	n transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter I indepthing	Dua to (c	or as a consaqu	uance of):					
× 6878	ding prysicis	Medical	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (c	or as a consequ	ience of):					
Во	attending for use a	Physician									
0	the	ysic	Part II. Other significant conditions con-	tributing to death but not res	sulting in the un	derlying caus	e givan in Part I.	23b. Did	obacco use co	ntributs to th	hs cause of death?
S, P.	requires their maloating the attended for us	by Ph						10	Yss 2 X No	3 Probat	bly 4 ☐ Unknown
9	28 5	Completed						24a. Was parfo	an autopsy rmed?	availe	a autopsy findings able prior to plation of cause ath?
	ate h	Con						10	res 250No	1 🗆 Y	res 2 No
of Vital	this certificate he ral director, page	Be	25. Was case referred to madical examiner?				26. Place	of Daath (Check only o	na)		
	this ce	L 0	1 ☐ Yes 2 🕱 No	ospital: 1 ☐ inpatient 2 ☐	ER/Outpatient	3□ DOA	Othar: 4 Nur	sing Home 5 Aesid	dence 6 □Oth	er (Specify)	
	thar than	ation:	27. Manner of Death  1 SNatural  2 Accident  5 Pending Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work? 1 ☐ Yes 2 ☐ N		now Injury occur	red	
Division	within 24 hours effer death.  To the Funeral Director: Affector: Affector: Affector: Affector in by the fur	Certification:	3 Suicide 6 Could not ba 4 Homicide determined	28e. Place of Injury - At h building, atc. (Special	ome, farm, stre	et, factory, of	fica	28f. Location ( City or Tox	Straet and Numb vn, State)	er or Rural R	loute Number,
2	within 24 hours effer of To the Funeral Direct completely filled in by	edica	29a. Certifier (Check only one) 12 Certifying Phys	iclan: To the bast of my known:  On the basis of examination and manner stated.	owledge, death ation and/or Inve	occurred at the estigation, in	ne time, data and my opinion, death	place, and due to that occurred at the time,	cause(s) and ma date and place,	innar as state and due to th	ed. na cause(s)
	To th	M	29b. Signature and title of certifier			29c. Li	cense number		29d. Date aigne	d (Month, Da	iy, Year)
)	2		Deffey Maga	ymer, MD		D	005194	4	Septemb	er 27	2,1998
	)		30. Name and address of person who con Jeffrey Magaz		m 23a) (Type, F	Print)	Carolino	4 Street,	Battim	one 1	1D 21287
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa		par V	,				



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate of De		Reg. No.	28879
	Physicia · /Medica		1. Decedent's Neme (First, Middle, Last)  Henry Tordan	Dete of Month	of Deeth	8 445
	Examine Funeral Director	r	4a Facility Neme (If not institution, give street and number)  4b. C  4b. C  F  5. Social Security Number  6. Sex,  7. Age (In yrs. lest birthday) If Under 1 Year If Under 1 Year	Under 24 Hrs. 8 Dete	e N/	ath A  uthplace (State or Foreign Country)
			Usuel Residence of Decedent  10e. Stefe 10b. County 10c. City, Town or Location		144	10d. Inside City Limits
	Maryla -f eho	ō	Maril 1 MIA Baltimore			1 DYes 2 □ No
	or 28a	Director	10e. Street end Number 10f. Zip Code		10g. Citizen of Whet C	Country?
	s 23a		3313 Poplar St. 212	16	US	A
020	E 0 B	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	nic Origin? (Specify Yes dexicen, Puerto Rican, etc	or No- c.) 14. Reca - Am Bleck, Wh Specify:	
1215-0020	s within 72 hours liene. r than "natural", the Magical Ext	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondery (0-12)  16e. Decedent's Usual Occupation (Give kind of work done durin, lifte. DO NOT use retired)	n ng most of working	16b. Kind of Business	s/Industry
d 21	年工芸を		17. Fether's Neme (First, Middle, Last) 18.	Mother's Neme (First, M	liddle, Meiden Sumeme)	usk
/lan	0 9 - 2	To Be	uat			unk
e, Marylan	l and 2 sho lealth and m 27 le me her treume		19e. Informent's Name/Reletionship (Type, Print)  19b. Mailing Address (Street and in the first of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Na	Heights A	ve, Balto, M	1d. 21207
altimor	Peges ment of It ant: If Ite lury or of		20e. Method of Disposition  1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State  4 ☐ Donetion 5 ☐ Other (Specify)	9/24/9	20c. Location - City of Lansdo	sune Md.
Bal	permit. Departminports any inju		21. Signature of Funeral Service Licen 22. Name end Address of	Facility KUSS F	uneral Ho	Me 121216
	-01-1		23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, su sheck, or heet failure. List only one ceuse on each line.	uch es cardiac or respiret	ory arrest,	Approximete Intervel Between Onset end Deeth
	Physician /Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)  e. Sepso — meur	nomia		Linkhown
	P 1	iner	Due to (or es e consequiçõe of):  Winary Dact (v	n fectic	Pa.	Mukaren
	n and latition	Exan	Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying cuse, (Disease or Injury c. Ceremon has called and consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence	1001	0. F	UniVar
3790	1	lical	Ceuse (Disease of Injury thet initiated events resulting in deeth) Lest  Due to (or es e consequence of):	HUGO	cent	- WE A DEL
X		//Wec	· OSteomyelitis			luknown
. Box	d for	SCIBL	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Pert I 23b	. Did tobacco use contribu	te to the cause of death?
s, P.O	ns that the gned by the be detache	by Physician/M	Maltiple Decubitas ulcar	2		Probably 40 Unknown
Vital Records,	s been si 2 should i	Completed	Seizure disorder	240.	Wes en eutopsy performed?	b. Were eutopsy findings evelleble prior to completion of ceuse of deeth?
al B			Hental detardation		1□ Yes 2 No	1□Yes 20 No
	1 50	o Be	exeminer?	5. Piece of Deeth (Check	only one)  Residence 6 □Other (Sp	necify)
n of		ou: 1	27. Menner of Deeth 1 Naturel 5 ☐ Pending 28e. Date of Injury (Month, Day Year) 28b. Time of linjury Work? 28c. Injury et Work?		cribe how injury occurred	
Division of	after death. Director: After	Certification:		2 □ No  28f. Loca City	tion (Street end Number or i or Town, State)	Rural Route Number,
	Hospi 24 hou Funer etaly III	edicai Ce	29e. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time, deeth occurred et the time,	dete end piece, end due to on, deeth occurred et the	o the ceuse(s) end manner at time, date end plece, end di	as steted. ue to the ceuse(s)
	To the within 2 To the comple	Me	29b. Signeture end title of certifier 29c. License nu	mber 7 7	29d. Date signed (Mor	1110
			1 (1) D335	5 6 2	Deplember	15,1998
	8		30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)  Ha Te 2 Velsee, N.D. LHC Bell	mono	Heights	Ave
	Stat	е	31. Dete filed (Month, Day, Year) 32. Registrer's Signeture	/		



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year -AURA JEFFERS 4c. County of Death 1998 SEPTEMBER 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth OF BALTIMORE BALTIMORE HOSPITAL If Under 24 Hrs. 8. Date of Birth Min. (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Yeer 9. Birthplace (State or Foreign 213-14-87 1 M 2 F Months Days Usuel Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits Maryland 1 ☑Yes 2 ☐ No IMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian. 11. Maritel Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: 3 ☐ Widowed 4 ☐ Divorced Itrican 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 51 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) 20e. Method of Disposition 20b. Place of Disposition (Name of comptery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lidensee 22. Name and Address of Fecility ome ra 21216 23a. Pant/Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one couse on each line. Approximete Interval Between Onset and Death Immediate Cause (Final GANGRENE OF FOOT RIGHT 15 DAYS disease or condition resulting in death) Due to (or as a consequence ot) DAYS SEPSIS 15 Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): ERIPHERAL VASCULAR DISEASE YEARS Due to (or as a consequence of): YEARS DIABETE MELLITUS 23b. Did tobacco use contribute to the cause of death? Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy tindings evailable prior to 24a. Wes an autopsy performed? completion of ceuse of death? 1 Yes 2 No 1 Yes 2 No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Unpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work?

Division of Vital Records, P.O. or Attending

Physician/Medical

þ

Completed

Be

2

Certification:

Medical

State Registrar

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

must be r

7 is marked other than "naturel", or items traumatic event, the Medical Examiner in

permit. Pages 1 and 2 should be filed within 72 hours after c Depertment of Health end Mental Hygiene. Important: If Item 27 Is marked other than "naturel", or ther any Injury or other traumetic event, the Moolest Examina-

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0020

the Marylend

Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I.

HYPERTENSION

1 Yes 2 No 27. Manner of Deeth

1 Naturel 5 Pending investigation 2 Accident 6 Could not be determined 3 Sulcide

1 ☐ Yes 2 ☐ No

P10442

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29e. Certifier

28f. Location (Street end Number or Rural Route Number, City or Town, State)

SEPTEMBER

(Check only one) 29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end manner stated.

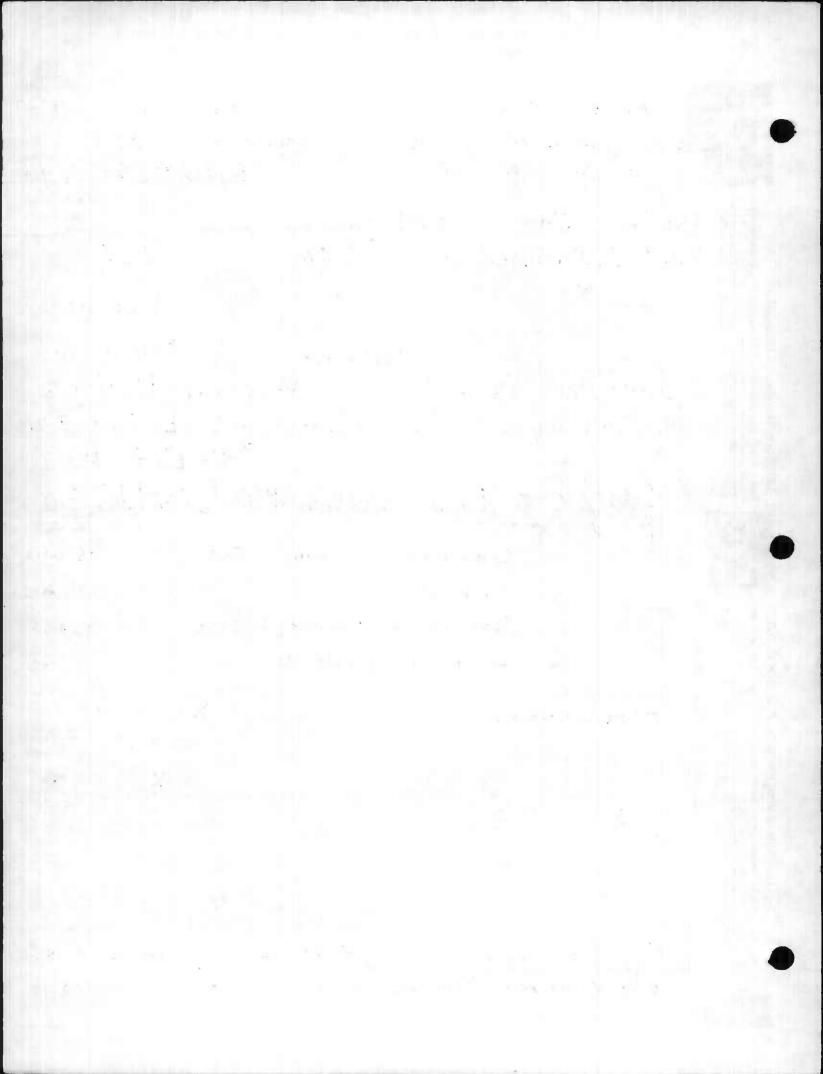
moanne MD 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

SINAI HOSPITAL OF BALTIMORE, MD 21215 JOHN WIL

31. Date filed (Month, Day, Year)

32. Registrar's Signature



LORRAINE R. JAMES

State of Maryland / Department of Health and Mental Hygiene

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See a		$\cup$	$\cup$	- 1

ITEMS:	#23	PART	I,	27,	PER	MEO	G764	10-1-98	WR.
		1. Dec	cedar	t's Nar	na (Firs	t, Midd	la, Last)		
Phys	sician	1.10	or	rai	ne	R.	Jan	ies	

4a Fecility Neme (If not institution, give street end number)

Certificate of Death

3. Time of Deeth 2. Deta of Death Month Yaa

WICOMICO COUNTY

Physician
/Medical
Examiner

Lorraine R. James

SEPTEMBER 12, 1998 4b. City. Town, or Location of Deeth 4c. County of Death

SALISBURY

1445PM

Birthplece (State or Foreign Country)

MD

10d. Inside City Limits

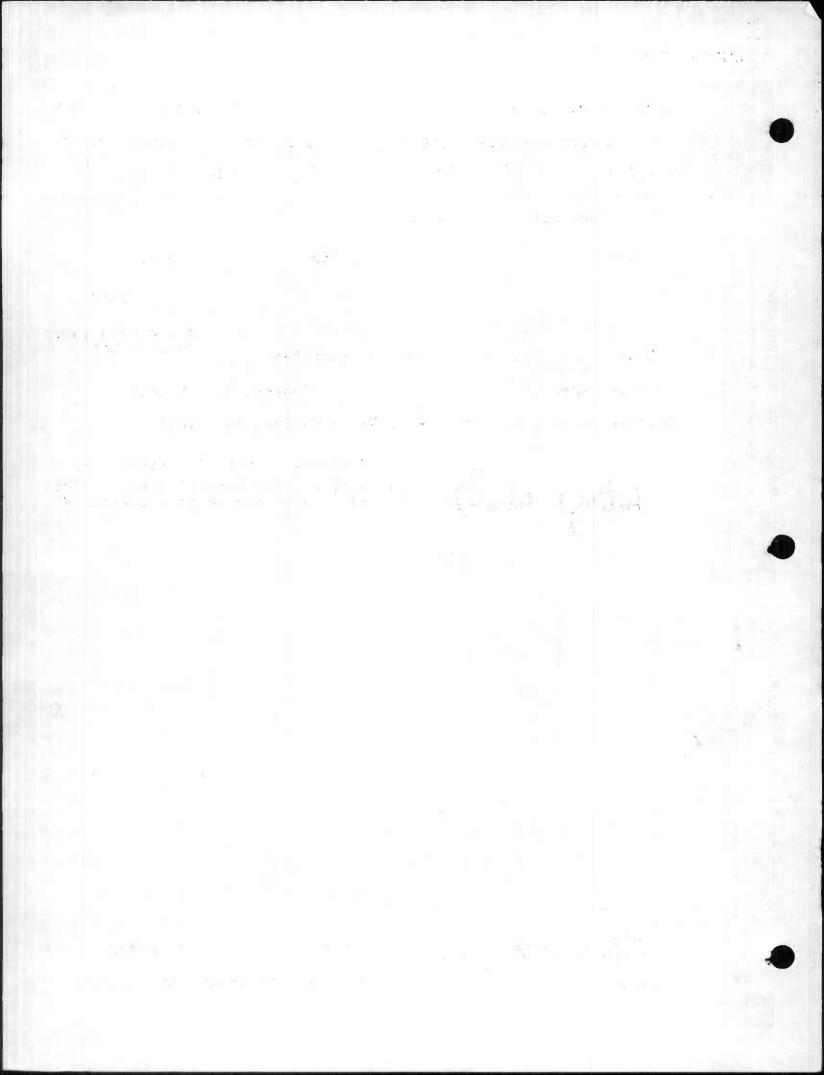
1 ☐ Yes X☐ No

PENINSULA REGIONAL MEDICAL CENTER E.R. 10e State

7. Age (In yrs. lest birthday) If Undar 1 Yaar If Undar 24 Hrs. 5. Sociel Security Number 6. Sax 8. Date of Birth (Month, Dev. Year) **Funeral** 1 M 2 XF Months Devs . Hours Min Yrs. 219-78-2928 34 7-14-64 Director Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland sent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location r 28a-f show show MD Somerset Director Marion 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23s or odical Examiner must be P.O Box 21853 U.S. Funerai 12. Was Dacedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yaar or Detes: Wes Decedent of Hispanic Ortgin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Alice Byrd Tawes Elemantery/Secondary (0-12) Cotlege (1-4or 5+) Nursing Home 12th yr. Nursing Assistant 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Charles James Engrett H. McKinney 19a. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 la P. 0. Charles James - Father Box 9 Marion, MD 21838 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cametery, crematory or other plece) 20c. Location - City or Town, Stata Dete 1 Burial 2 Cramation 3 Ramoval from Stata permit. Page Department of Important: If any injury or = 0 4 ☐ Donetion 5 ☐ Other (Specify) Peer Cemetery Mt. 21. Signeture of Funeral Service Licensee r complications that caused the death. Do not antar the mode of dylng, such as cardiac or raspiretory errest, it only one cause on each line. **Physician** /Medical Immediete Ceuse (Finet disease or condition resulting in deeth) CARDIOMYOPATHY Examiner Due to (or es e consequença of): Examiner and I-transit law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): physician ar P.O. Box 68760. Physician/Medical Due to (or as a consequance of) signed by the a Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. Division of Vital Records, by should I Completed cartificate has b The Yes Hospital or Attending Physicisn: 24 hours after death. Funeral Director: After this cartifica stely filled in by the funeral director, i Be 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) 2 1XYes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of Certification: 28c. Injury et Work? 5 ☐ Pending investigation 1 Neturet Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ HomicIde To the Hospital or within 24 hours att To the Funeral Di completely filled in 29a. Certifier Medicai (Check only one) 29b. Signatura and time of certifian

9-19-98 Marion, MD 22. Nema end Address of Fecility Anthony E. Ward Funeral Home 21853 30639 Hampden Ave. Princess Anne. MD Approximata Intervel Between Onset and Death 23b. Did tobacco use contributa to the cause of death? 4 Unknown 1 Yss 2 No 3 Probably 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? completion of cause of deeth? Yes 2 No 2 - No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner steted. 29c. Licansa number 29d. Data signed (Month, Day, Year) O.C.M.E. SEPTEMBER 13, 1998 my 30. Name and address of person who completed caused death (Item 23e) (Type, Print) Mik. 111 Penn Street, Baltimore, Maryland 21201 31. Dete filed (Month, 'Day," Year) 32. Registrar s Signature

State Registrar THEDROPE



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#29c per DVR G763 9/22/98 EW 1. Decedant's Name (First, Middia, Last) 2. Data of Death 3. Tima of Death **Physician** /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Deat Examiner ALTIMORE If Under 1 Year If Undar 24 Hrs. 9. Birthplaca (Stata or Foreign Country) 5. Social Security Number Aga (In vrs. last birthday) **Funeral** -26-7423 Days 10 M 20 F Months 66Yrs. Director Usual Rasidance of Decedant the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location r is marked other than "natural", or thems 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Yas 2 No Director 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? Funeral death 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Give Yaar or Datas: 14. Raca - Amarican Indian, Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status Biack, Whita, atc. 1 Never Married 2 Married 1 Yas 2 No Spacify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) filed within Eiamantary/Sacondary (0-12) Collega (1,4or 5+) Hygiene. 18. Mother's Name (First, Middle, Malden Sumama) en's Nama (First, Middla, Last) Be pemit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If Item 27 Is marked off Pages 1 and 2 should be nent of Health and Mental Print) Daughter 19a. Informant's Name/Ralationship (Type 19b. Meiling Address (Straat and Number or Ruraj Routa Number, City or Town, Stata, Zip Coda) MORE, MD 212 20c. Location - City or Town, State MD 21229 20b. Piace of Disposition (Nama of cematary, cramatory or other) 20a. Mathod of Disposition Data 1 Burial 2 Cramation 3 Ramovai from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 1402/21 23a. Part1. Enter the disease, or complications the leafused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Cancer bmonths **Examiner** Dua to (or as a consequence of): Physician/Medical Examiner per concernio The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Diseesa or Injury that Initiated evants rasulting in daath) Last Dua to (or as a consequence of): Dua to (or as a consequence of): signed by the at Id be detached fo Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Vaa 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? peen completion of cause of death? page 2 has 2 1 No 1 Yas 1 ☐ Yas 2 ☑ No certificate director, 25. Was case rafarrad to medicel axaminar? Be 28. Placa of Daath (Chack only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2 No 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Dascribe how injury occurred 27. Manper of Death Certification:

Box 68760. Records, Division of Vital or Attending Physician: After this funeral To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fu after death.

Maryland 21215-0020

Baltimore,

1 Netural 5 Panding Invastigation 2 Accidant

8 Could not be

28e. Data of injury (Month, Day Year)

28b. Time of Injury 28c. Injury at Work? 1 Yas 2 No 28a. Piace of Injury - At homa, farm, streat, factory, office building, atc. (Spacify)

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 1 Cartifying Physician: To the best of my knowladga, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier

29c. Licansa number D51984 29d. Data signad (Month, Day, Year)

JIH # 06235

21287-8195

30. Nama and address of person who complated ceusa of death (Item 23e) (Type, Print)

600 N. Wolff St. Michael KRABAK Bultmac MD .D

31. Data filed (Month, Day, Year) State SEP 2 2 1998

3 Sulcida

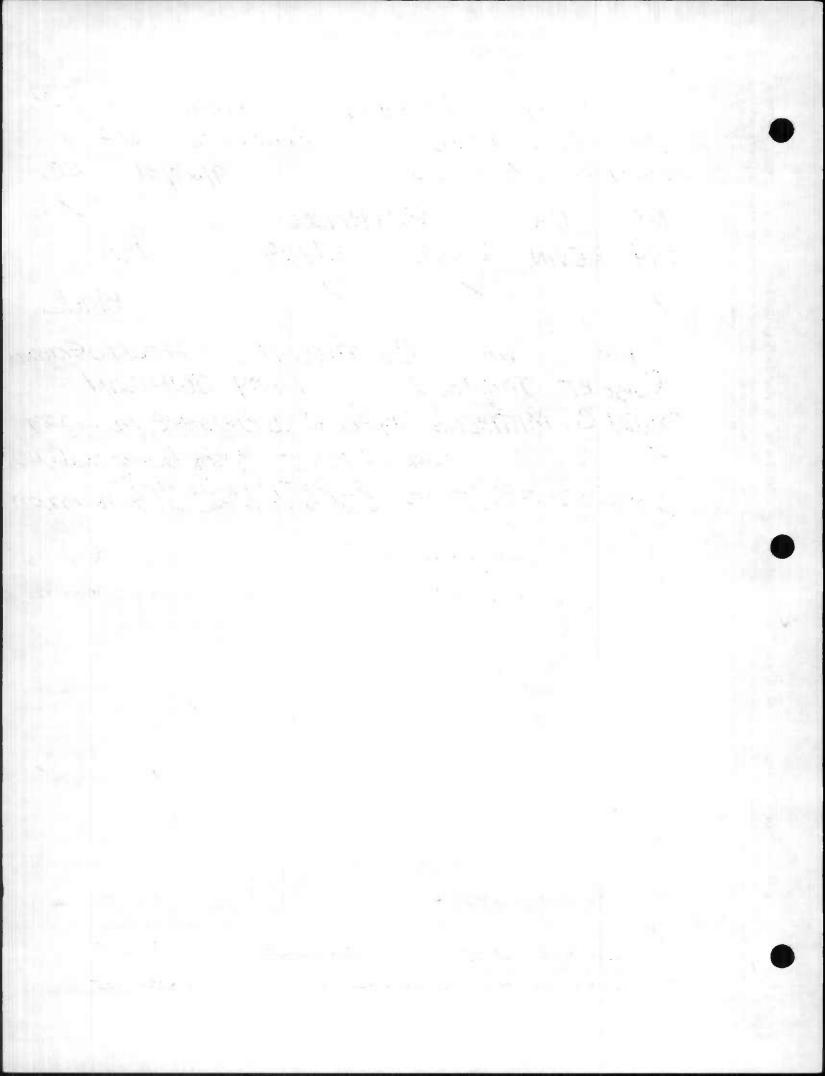
29a. Cartifiar

32. Ragistrar's Signatura

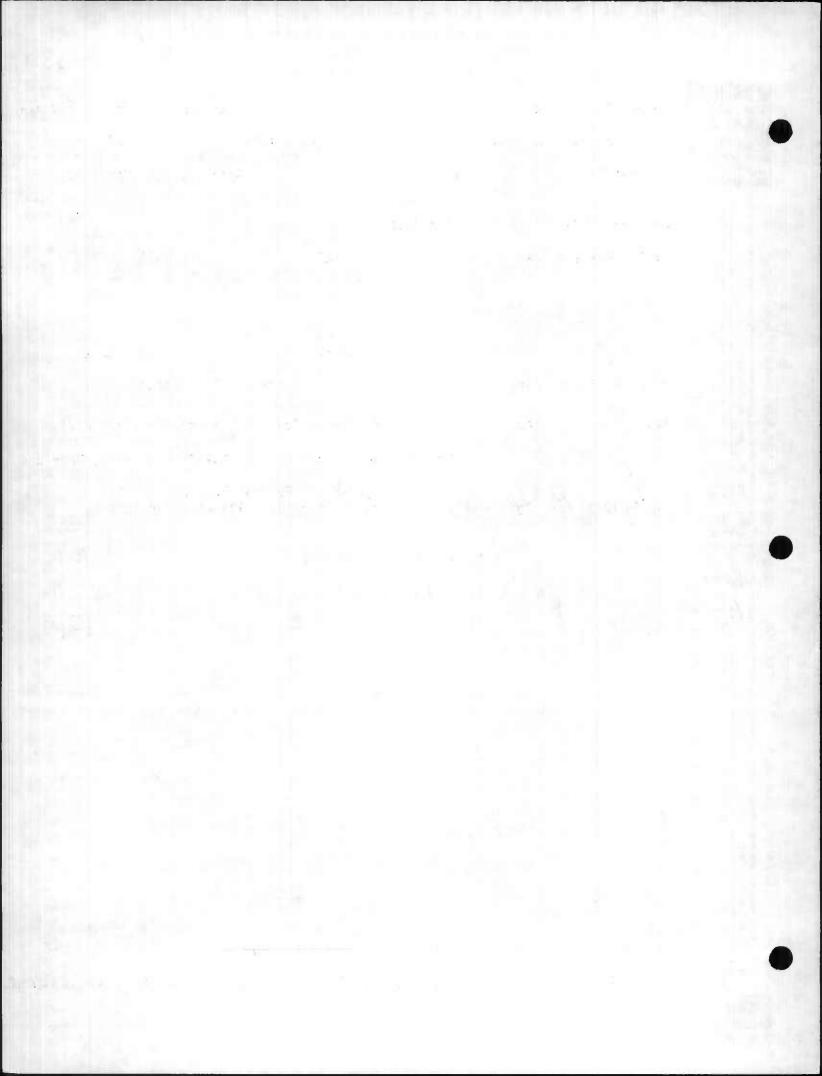
Registrar

edical

DHMH 16 Ray 6/95



Item#	#29c per DVR G763 9/22	/98 EW	iviai yiailu		tificate of		-	Reg. No.	28883
cian dical	1. Decedent's Name (First, Middle, L Mary Jane Ki	ng					2. Date of De Month September	Day 10 1	3. Time of Deeth 7:45 pm
iner	4a Fecility Neme (If not institution, grundle Union Memorial		oer)			Baltimo	Location of Death	1	N/A
ai e		•	Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt	th y, Year)	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent  10e. State 10b. County		100 000	Town or Loc	ation				10d Inside City Limite
tor	Maryland N/A			imore					10d. Inside City Limits  1/□Yes 2□ No
Director	10e. Street and Number		Dare	711101 C	10f. Zip Code			10g. Citizen of V	Vhat Country?
	1506 Milrace	Road			2121	1		USA	
by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Novorced	12. Was Decedd Armed Force 1 Tes 2 If Yes, Give Year or Date	<b>□</b> No		Vas Decedent of H Yes, specify Cuba ☐ Yes 🏋 No	dispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	- 14. Race Blace Specify	e - American Indien, ik, White, etc. : White
sted	15. Decedent's E			16a. Deced	ent's Usual Occup	pation during most of w	orkina	16b. Kind of Bu	usiness/Industry
Completed	Elementery/Secondary (0-12)	College (1-4	or 5+)		kind of work done O NOT use retire  omemaker			0	n Home
3	17. Father's Neme (First, Middle, Las	t)			omemaker		ame (First, Middle,		
	Milburn Frank	King				Harr	iet Ola	Co1ema	n
	19e. Informant's Name/Relationship						Rural Route Numb		
	Max Shields 20a. Method of Disposition	Son	20b. Pled		b Milrac	e Road,	Baltimor		land 21211 City or Town, State
	1  Burial 2  Cremation 3		ate cerr	etery, crem	atory or other planapel Cen		9/14/9		Hall, Maryland
	21. Signature of Funeral Service Lice				Name and Addre		3/11/3	NOCK	marr, maryrana
	John B	Olean	$\sim$	Bu	rgee-Her	iss Fune	al Home	PA 2	1211
	23a Part I Sther the disease, or construct, or heart feilure. List only	nplications that cau	used the death.	Do not ente	or the mode of dying	ng, such as cardi	ac or respiratory a	mary I	Approximate Interval Between
	Immediale Cause (Final disease or condition resulting in death)	-			ratory uence of): Heart	-			Onset and Death  15 yrs.
e	resulting in death)	Ca	Due to (or a	s a conseq	uence of):	En P.	1		5.450
Examin	Sequentially list conditions	b. C&	Due to (or e	s e conseq	uence of):	141100			Jyrs.
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		Hyper	tens	ion				loyrs
1	that initiated events resulting in death) Lest	V	Due to (or e	s e consequ	uence of):		3 74 8		
		d							
	Part II. Other significant conditions	contributing to deal	th but not resulti	ng in the un	derlying ceuse gh	ven in Part I.	1		ntribute to the cause of death?
							1/4	Yes 2□No	3 Probably 4 Unknown
								an autopsy omed?	24b. Were autopsy findings available prior to completion of cause of deeth?
							1 🗆	Yes 2 No	1 ☐ Yes 2 ☐ No
	25. Was case referred to medical exeminer?	4.0= . = 24 = 1			J.o.		eath (Check only	one)	
0	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Ing		NOutpatien  8b. Time of	3LI DOA		Home 5 ☐ Resi	dence 6 Oth	
Certification:	1 Natural 5 ☐ Pending	(Month,	Day Year)	Injury	28c. Inju Wo	rk?  Yes 2□No	200. Describe	now injury occur	100
20111120	2 Accident Investigation 3 Suicide 6 Could not determine	be 28e. Pleca o	f Injury - At hom , etc. (Specify)	e, farm, stre	eet, factory, offica		28f. Location ( City or To		per or Rural Route Number,
edical	29a. Certifier Check only one) Certifying P	hysician: To the be miner: On the bas and manne	is of examinetion	edge, death n and/or inv	occurred at the tilestigation, in my	me, date end pleo opinion, death occ	ea, and due to the curred at the time,	cause(s) and ma dete and pleca,	anner es steted. and due to the ceuse(s)
Me	29b. Signature and title of certifier				29c. Licens	se number P12	726	29d. Date signe	d (Month, Day, Year)
	1 Holle H	Lyange,	M.D		AT			September	er 10, 1998
	30. Neme end eddress of person who	111	of death (Item 2	3a) (Type, I	Print)	1000			er 10, 1998 MARYLAND 2121
	ABIKE DUROJA  31. Dete filed (Month, Day, Year)	YE 20	EAST	UNI	VERSIT	PHKKU	AY BALL	IIMORE	MARYLAND 2121
e	CED 9 9 4	000	Trai a Signetur						



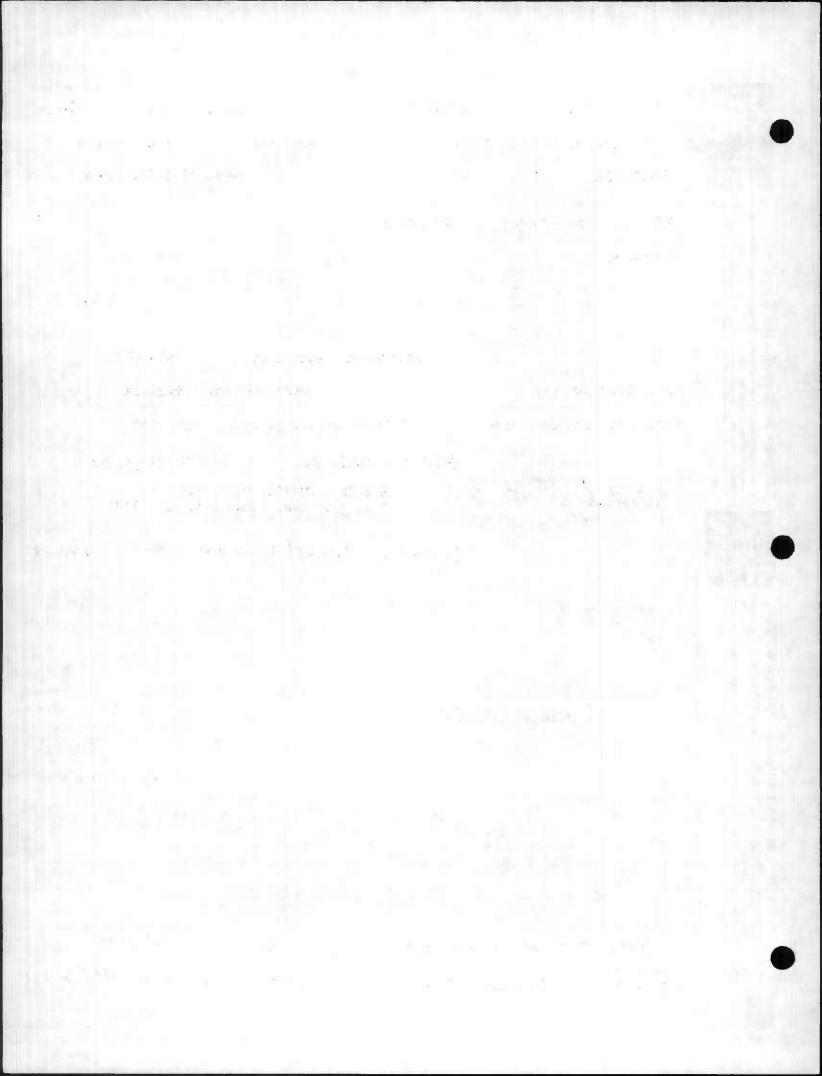
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth 3. Time of Death Month **Physician** Krupsky Karl Sept.17, Peter 1998 3:00 pm /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 10XM 2□ F Days Yrs. 66 **Director** Sept. 28,1931 167-26-4751 Pennsylvania Usual Residence of Deceden with the Merylend 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic svent, the Modical Examinat must be notified at 1 ☐ Yes 2 No Directo Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiena. Important: If flem 27 is marked other than "natural", or ferma 23a eny injury or other traumatic event, the Medical Examinar encouns. 112 Meade Drive 21403 USA Funeral 12. Was Decedent Ever in U,S. Armad Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 XYas 2 No If Yes, Give Year or Dates: 1952–56 1 ☐ Never Marriad 2X Married altimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) U.S. Navy 12 2 Electronics Technician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Karl Peter Krupsky Mary Catherine Chermeta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 112 Meade Drive, Annapolis, MD 21403 Sandra E. Krupsky - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cramation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 9/21/98 Elkridge, MD 22. Nama and Addrass of Facility 21. Signature of Funeral Servica Licensee Hardesty Funeral Home, P.A. also leno 12 Ridgely Ave. Annapolis, MD enter tha mode of dying, such as cardiac or respiratory errest, 21401 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** coronary disease myocardial infarct Immediate Ceuse (Final disease or condition resulting in death) Lhour /Medical Examiner Due to (or as a consequenca of): Examiner May. the burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medicai Dua to (or as a consequanca of): 88 esn. 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Bladder cancer signed t þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of deeth? paga 2 hes 2 200 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical exeminer? director, Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetlent 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo 1 Yes 2 No this funeral 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: After or Attending 1 Vaturei 5 ☐ Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: Af investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, and due to the cause(s) and menner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. To the F 29d. Data signed, (Month, Day, Year) 29c. License number 9/18/98 elouilly, uno 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 8 Bertgate Annapolis, Md. 21401 selouicu, M.D. 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture

DHMH 16 Rev 6/95

State

Registrar

SEP 2 2 1998



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth enser 18

**Physician** /Medical Examiner

**Funeral** Director

the Maryland 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinat must be notified at death

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
mt: If item 27 is marked other than "natural", or ite other 1 permit. Pages Department of Important: If it any injury or o

Baltimore,

**Physician** /Medical **Examiner** 

2 Completed page 2 Be 9

25. Was case referred to medical examiner?

5 Pending investigation

6 Could not be determined

1 Yes 2 No

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

certificate 書 funeral Division after deatl Director: ò A Puneral D Hospital To the P within 2 To the P

State Registrar

Certification:

Medical

1. Decedent's Name (First, Middle, Last) VINCENT PERCY 4c. County of Deeth 4b. City, Town, or Location of Deeth 4e Fecility Name (If not institution, give street end number) LEVINDALE HEBREW GERIATRIC CENTER & HOSP. BALTIMORE N/A if Under 24 Hrs. 8. Dale of Birth (Month, Dey, Year) JAN 24, 1909 If Under 1 Year 7. Age (in yrs. lest birthdey) 9. Birthplece (State or Foreign 1 M 2□ F Months BALTIMORE, MD. Days 89 217-09-5999 Usual Residence of Decedent 10d. Inside City Limits 10a Stale 10b. County 10c. City. Town or Location 1 N Yes 2 No Directo MARYLAND BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4800 YELLEWWOOD RD. 21209 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: AFRO. AMERICAN by 3 ₩ Widowed 4 Divorced Yeer or Dates: Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DEPT OF TRANSPORTATION BALTIMORE CITY SCHOOL 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) HENRY PERCY LEE BERTHA HARRIS 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 817 MCKEAN AVE, BALTIMORE, MARYLAND 21217 ETHEL BERKLEY 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Locetion - City or Town, State 1 Durial 2 □ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) 9/24/98 BROOKLYN, MARYLAND MT. CALVARY CEMETERY 21. Signature of Funeral Service Lice ESTEP BROTHERS FUNERAL HOME, P.A. LLQYD M. ESTEP 1300 EUTAW PLACE, BALTIMORE, MARYLAND ations that of used the deeth. Do not enter the mode of dying, such es cardiac of seuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Diseese or injury thel Initiated events resulting in death) Lest Physiclan/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at 4 Work? 1 Yes

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

2 □ No

29c. License numbe

1 ☐ Yes

24a. Was en eutopsy

Certifying Physicfan: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Dale signed (Month, Dey, Year)

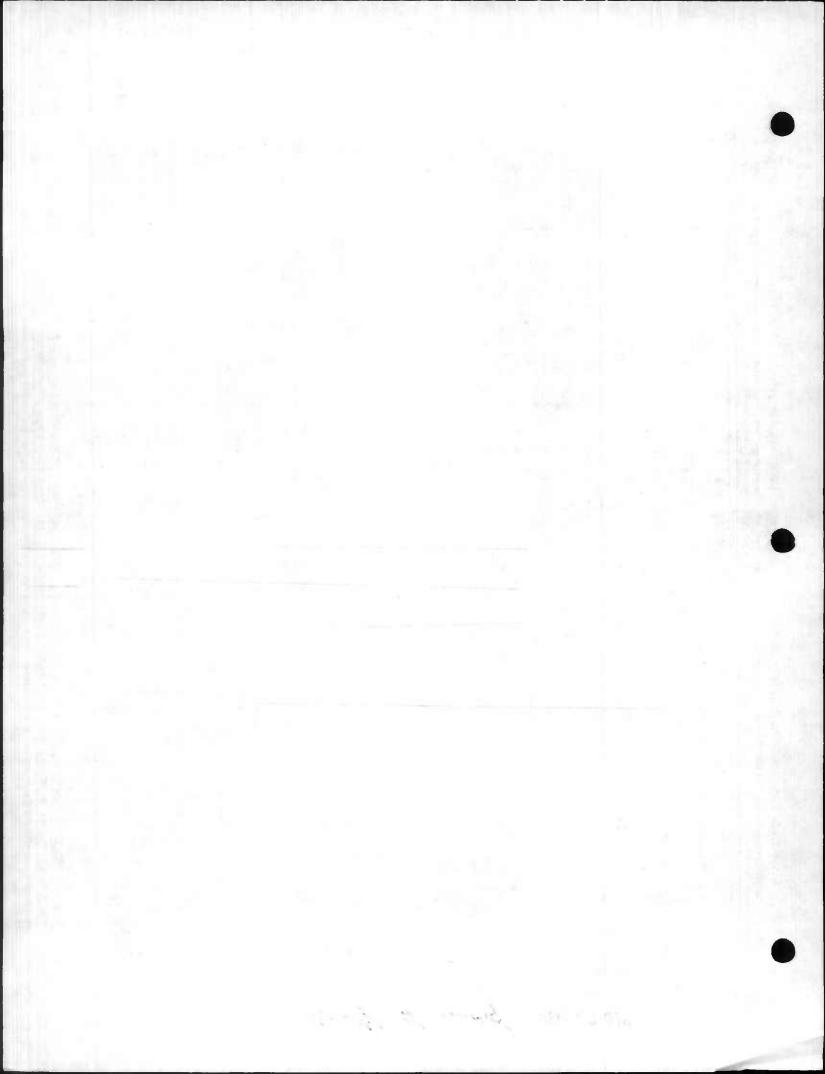
24b. Were eutopsy tindings evallable prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

32, Registrar's Signature 2 2 1998

Street My the 3 and stay and anguesthy Thousand regard that is dideflicat home was a grade a fall of the

Amend: #23a	Par	t Ia,b,c,Part II Per MD	Film G763 9-24				1	ene 98	2888	6
Physicia /Medic		1. Decedent's Name (First, Middle, Last)	c. dowis	8			2. Date of Death Seot.	Day 19	Year 7:0	Onm.
Examine Funeral Director	er	20-20-1190	a Rd.	s. last birthday)	If Under 1 Yeer Months Days	4b. City, Town, or Lo		4c. County of Bal	Death  HUNGE  9. Birthplace (State or Country)  MARY	Foreign
anyland		Usual Residence of Decedent  10a. State 10b. County	10c. C	city, Town or Loc	ation	7			10d. Inside City	
with the Maryland a or 28a-f ahow the notified at	Director	Md. Baltmi	ore 1	BUSO	10f. Zip Code		T 10	g. Citizen of W	1 Yes	21X No
th with	E C	11029 Mussula	Rd.		218	286		(108	A	
020 urs after deal', or flema	by Fur	11. Marital Status 12.  1 Never Married 2 Married 3 Widowed 4 DaDivorced	Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:		Vas Decedent of h Yes, specify Cub	lispanic Origin? (Spe an, Mexican, Puerto I Specity:	cify Yes or No- Rican, etc.)		- American Indien, , White, etc.	
21215- 3 within 72 plane. r than net	Completed	15. Decedent's Educat (Specify only highest grade of	ion ompleted) College (1-4or 5+)	(Give I	ent's Usuel Occup kind of work done O NOT use retire	during most of working	ng 1	6b. Kind of Bus 3 lack a	iness/Industry  A Wecker	0
yland buld be fil Mental H Mental H arked oth	To Be C	17. Father's Name (First, Middle, Last)	leitzer	106 Mallia		18. Mother's Neme	M. U	Vater	S	
Malth a saith a 27 is		19a. Igformant's Name/Relationship (Type,  20a. Method of Disposition  1  Burial 2 Cremation 3 Rem	20b.	5000 Plece of Dispos	3 Kenu	and Number or Rura	Balt	MORR.	Md 212C City or Town, State	)(0
Baltimore permit. Pages 1 a Department of He important: if item any injury or othe		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Wells		Name end Address Full 800 Ho	neral Cy	1998 /	Jackvil Janoel	le Maryi Md 212:	land 34
Physician /Medical Examiner	10	23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one dimmediate Cause (Finel disease or condition resulting in death)	Respira	CIRRHOSIS  (or as a consequence)	) ADVANCED	LIVER FAILU	RE F LIVER	St,	Approximete Interval Betw Onset and D	veen
cata be physicis	edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Deline	or as a consequence or as a consequence	Hon		,		7	
is, P.O. Box (satisfied by the attending be deteched for use as	Physician/M	Pert II. Other significant conditions contrib	outing to death but not re	sulting in the un	derlying cause on	ven in Pert I.			tribute to the cause of	of death?
Cord v requir been s should	Completed by F	DEHYDRATION -					24a. Wes an perform	eutopsy	24b. Were autopsy fit available prior to completion of ca of death?	indings
= F # 4 4 4		25. Was case referred to medical				OC Diseased Death	1 Yes		1 🗆 Yes 2 🗆 1	No
Of Vital Physicien: This certificat	9	examiner?		ER/Outpatient	3LI DOA		ne 5 Resider	nce 6 Other		
VISION Attending or death. ector: After by the funa	Certification:	2 Accident investigation	28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At I building, etc. (Spec	28b. Time of Injury		Yes 2 □ No	28d. Describe how 28f. Location (Str. City or Town,	eet and Numbe	r or Rural Route Numb	ber,
To the Hospital or Within 24 hours aft To the Funeral Dir completaly filled in		29a. Certifier (Check only one) (Contifying Physicial Examiner	an: To the best of my kn On the basis of examin and menner steted.	owledge, death ation end/or inv	occurred at the tilestigation, in my o	me, date and place, a	and due to the car ed et the time, da	use(s) and man te and place, ar	ner as stated. nd due to the cause(s)	)
To the comp		29b. Signature and title of certifier	40		29c. Licens	se number	29	d. Date signed	(Month, Day, Year)	
10	1	IO. Name and address of person who comp	leted cause of death (Ite	m 23a) (Tvpe. F	1)-1	1992		91	12198	
State		DR. Khum Tu	100( 32. Registrar's Sign	e Jay	10RAY	· Tow	50M, 1	ld. 21	286	
Registra	₹ .	SEP 2 2 1998	Deneva	· 1.	Sonk	2				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #5 Per FH Film G763 9-25-98RC Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** JOANNE LOWMAN 18 Sept. 1998 6:00pm /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 123 Trailways Road Baltimore Baltimore 7. Age (In yrs. lest birthday) If Under 1 Year 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 2 1950 9. Birthplece (Stete or Foreign Country) West Virginia Funeral Deys 1□ M 21 F Months Hours Yrs 48 **Director** the Maryland 10a, State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. inside City Limits MD Baltimore Baltimore Director 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 123 Trailways Road 21220 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No if Yes, Give Year or Dates: 11. Maritel Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. filed within 72 hours after thygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: p Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: if item 27 is marked other tha any Injury or other traumatic event, Ina. 2006. 10th Salesperson Retail Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Robert McCartin Betty Alexander 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Raymond Lowman / husband Baltimore MD. 21220 123 Trailways Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Commation 3 ☐ Removel from State Metro Crematory Inc. 9/22/98 4 ☐ Donetion 5 ☐ Other (Specify) Balitmore Md. 21. Signature of Funerel Service Licansee 22. Name and Address of Facility Connelly Funeral Home of Essex 300 MAce AVe. Baltimore Md. 21221 0 23a. Part1. Enter the disease, or complide ons thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only only ause on each line. Approximete interval Between Onset end Death **Physician** My Cardial Infantions
Due to (or es a consequence of):
or onary astry clisease
Due to (or as a consequence of): /Medical Immediate Ceuse (Final day disease or condition resulting in death) Examiner Examiner Due to (or as e consequence of): Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest and 68760 Physician/Medical Dua to (or es a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 2 1 Yes 2 No 3 Probably 4 Hhknown signed be del à 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed page 2 s 1 Yes 2 Ho 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Plece of Death (Check only one) Hospital: 1 inpatient 2 ER/Outpatient 3 DOA Other: 4☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Quatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Phya(cian: To the best of my knowledge, death occurred at the time, dete end pleca, end due to the ceuse(s) and menner es stated.

2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and plece, end due to the ceuse(s) end menner stated. Medical 29a. Certifler (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 0-28097 Ronald attainsonp 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) NORTH PT ROAD, BATTIMORE, Md. OLD

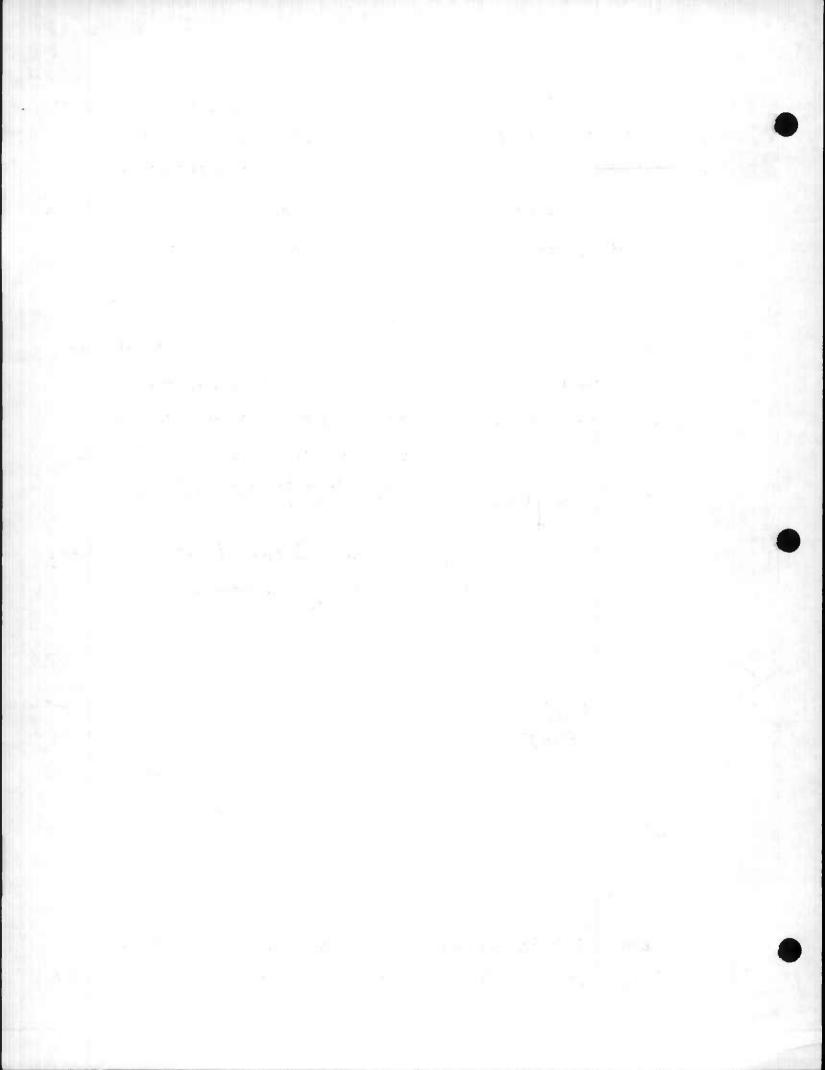
Registrar

State

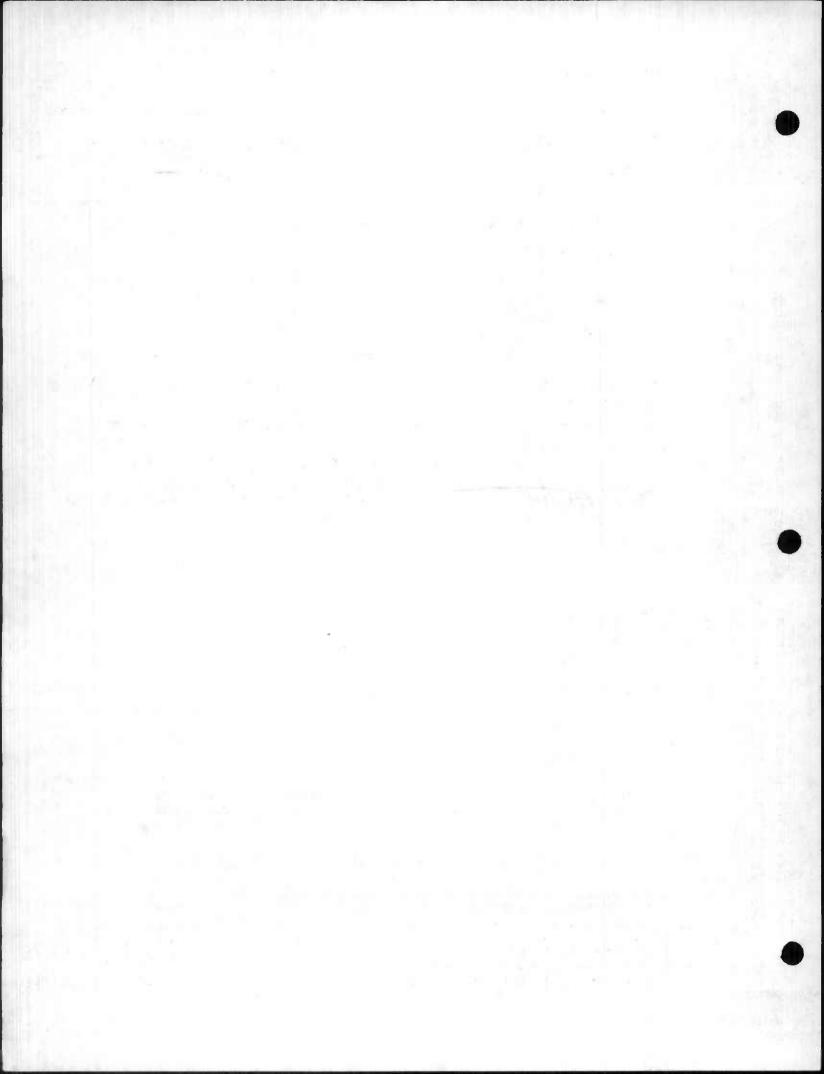
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32 Registrar's Signature

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Yas 2 No  Routa Number, ted. the cause(s)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 3. Time of Death 2. Data of Death Yaar 98 **Physician** MOORE 09 0744 Marcellus /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** of Maryland Baltimore Ba Himore System If Under 1 Year University MEDICAL City If Undar 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Sociel Sacurity Number 7. Aga (In yrs. lest birthday) Birthplece (State or Foreign Country) 6 Sex **Funeral** 1 X M 2□ F Months Days 421-22-3660 73 Director AL Usual Rasidance of Dacedani the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Baltimore Baltimore Macyland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? th and Mental Hygiena.
7 is marked other than "naturel", or items 29a or transetic event, the Medical Examiner must be a Peges 1 and 2 should be filed within 72 hours aftar deeth with ient of Health and Mental Hygiena. ROAD Hilton 350 21215 United States Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 14. Rece - American Indien Black, Whita, atc. 11. Maritai Status 1 XY s 2 No If Yes, Giva Yaer or Datas: 1 Navar Marriad 2 Married 1 Yas 2 XXX Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Dacedant's Education (Specify only highast grada complated) Collega (1-4or 5+) Elemantary/Secondary (0-12) Counselor MD House of Correcti 17. Felher's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Meidan Sumama) Johnnie McAniels Lee Ester Moore 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Address (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Peges 1 and 2 s Department of Health ar Important: if item 27 is any injury or other trau Christine Moore/wife 3501 N. Hilton St. Balto., MD 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stata Data 1 Number of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s Garrison Forest Va 9/24 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD 21. Signature of Funaral Service Licansee 22. Name and Addrass of Facility James A. Morton & Sons Funeral Home 23a Part I Enler the disease, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiretory arrast, another than tailure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** Immediata Causa (Final diseasa or condition resulting in daath) /Medical Frays Cardidoulmonne Examine Physician/Medical Examiner intra cerebellar Sequantially list conditions, if any, leading to immadiata causa. Enter Undarlying Causa (Disaasa or Injury thet initiated avants rasulting in death) Last 4 DAYS Coagulopathic
Due to (or as e consequence of): 2 Days Septic Pert II. Other significant conditions contributing to death but not resulting in the undarlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1□ Yes 20 No 3 Probably 4 Unknown HIRH BLOOM Pressure þ 24b. Ware eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed is certificata h 1 Yas 2 No 1 ☐ Yas 2 ☐ No Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical eleby filled in by the funeral director. Be 25. Was case referred to medical exeminer? 26. Pleca of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mannar of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending Investigation 1 Naturel 1 Yes 2 No 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 4 Homicida ted Certifying Physician: To the best of my knowledge, death occurred at the tima, date end place, end due to the causa(s) and mannar as steted. 29a. Cartifier Medical (Check only one) 2 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mennar stetad. To the F within 2 To the F 29b. Signeture and title of contine Paul Anserser # 7830 29d. Dala signed (Month, Day, Year) UnivofMg

Baitimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Registrar

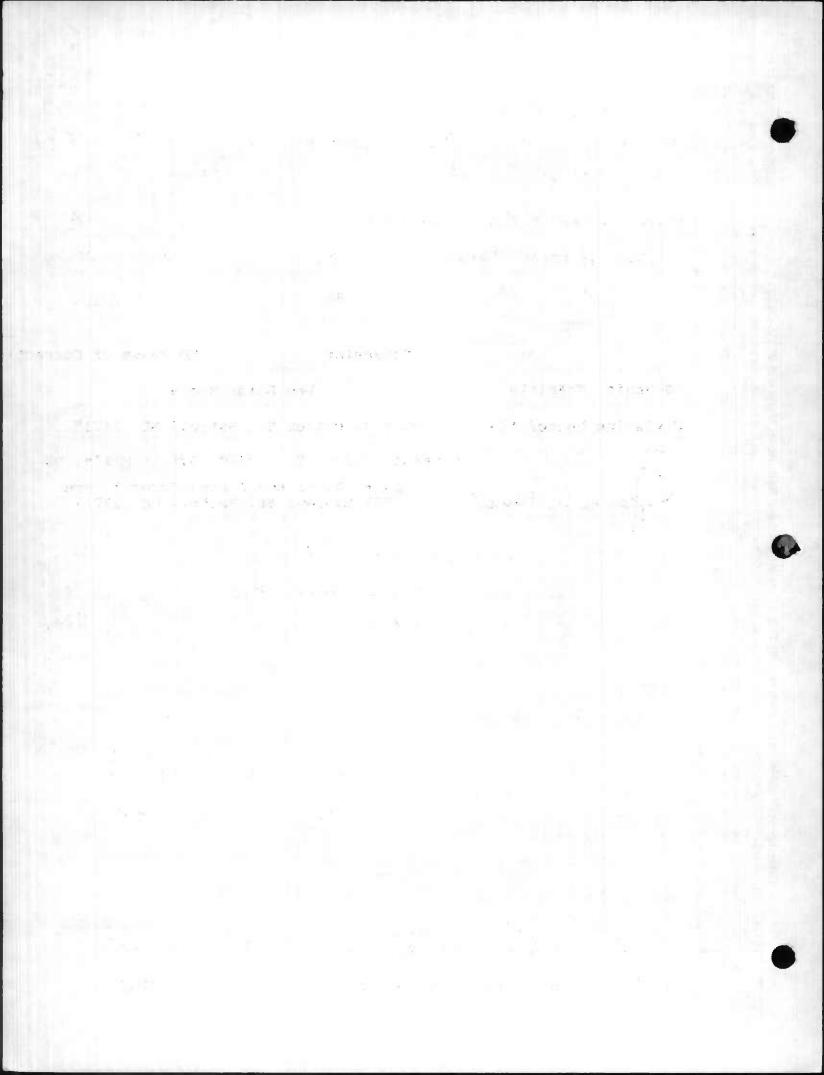
ANDERSON 31. Data filed (Month, Day, Yaar)

WATTEN 14B 32. Registrar's Signeture

30. Name end eddrass of person who completed cause of death (Item 23a) (Type, Print)

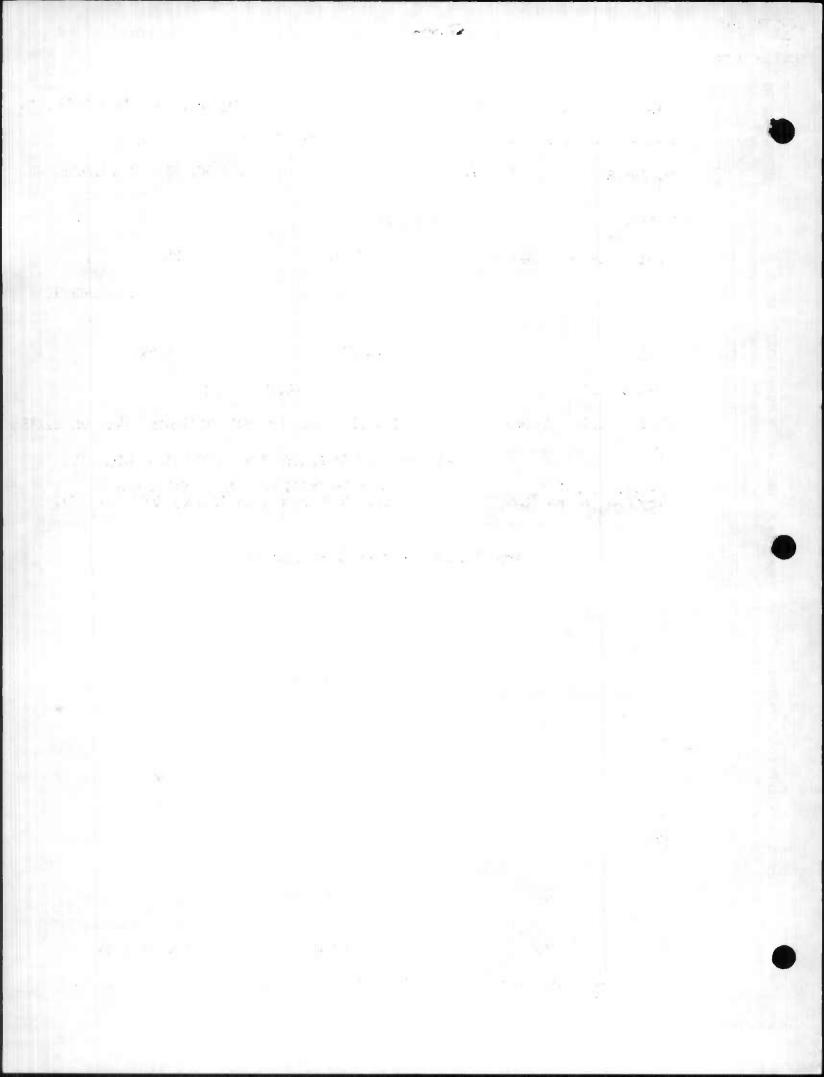
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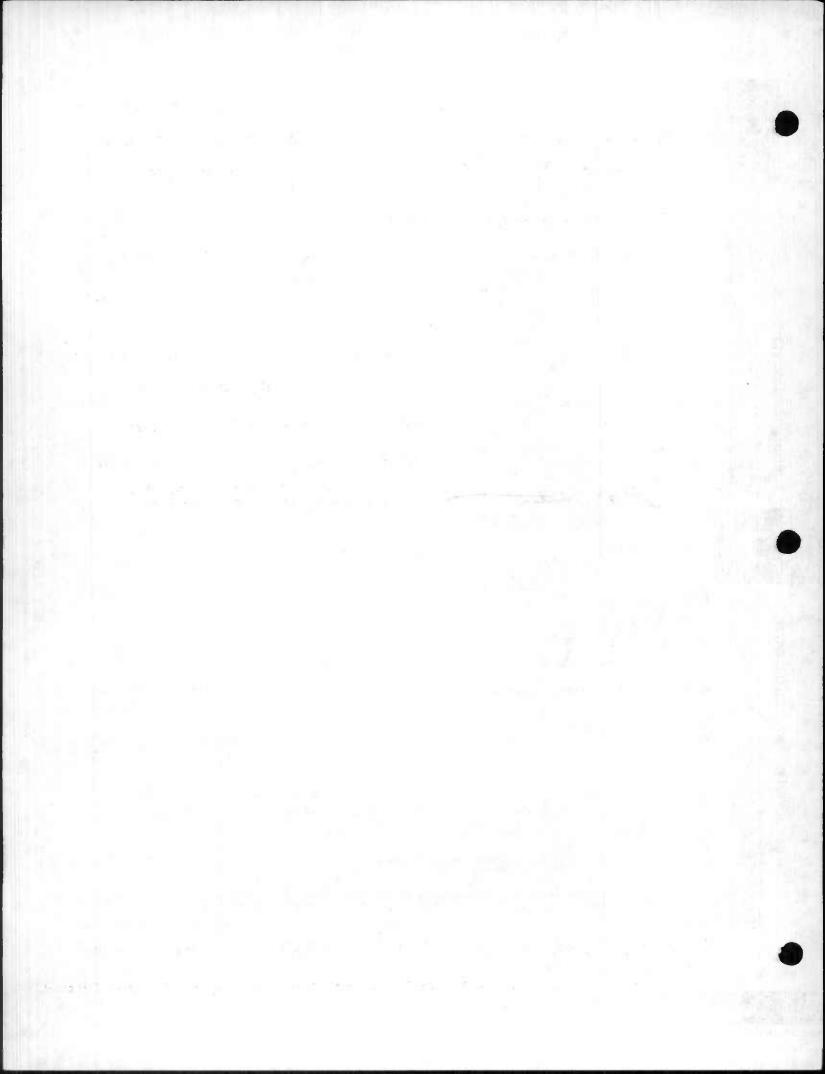
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	Examiner	4e Facility Name (If not institution, s Liberty Medical		mber)				Balti	imor	ocation of Deeth	4c. Count			
	Funeral Director	216-20-8844	. Sex 1□M 27 F	7. Age (In yrs. 73	lest birthday) Yrs.	If Under Months	1 Year Deys	If Under : Hours	24 Hrs. Min.	JAN 30	<sup>h</sup> 1925	9. Birthple BALII	MORE	or Foreign
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	alth end 27 is m r treum		USBAND	l non-	2501	VOIL	ET A	VE, A		906 BAL	TIMORE,	MARYL	AND 2	21215
Baltimore,	Pages 1 a lent of Hei nt: If item ry or othe	20a. Method of Disposition  1   ↑ Burial 2 □ Cremetion 3  4 □ Donation 5 □ Other (Spe		State	Plece of Disponentery, creametery, creametery				RY	Date 9/18/98	20c. Location OWINGS			
Balti	permit. Par Departmen Important: any Injury pnce.	21. Signature of Funeral Service Lic LLOYD M. ESTI	ensee		E	2. Name en STEP	d Addres	ss of Fecilit	FUNI	ERAL SER	RVICE.	P.A.		7
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	Physician /Medicai Examiner ਹੋ	Immediate Ceuse (Final disease or condition resulting in death)	e. Arte	rioscle	erotic or es a conse		.ovas	scular	r Di	sease	-3			
,	buriel-trensit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying	b	Due to (	or es e conse	quence of):								
687	e sy e	thet initiated events	c	Due to (	or as e consec	quence of):								
B.	for the	Part II. Other significant conditions	contributing to de	eath but not re	sulting in the u	nderlying c	ause giv	en in Pert I.		23b. Did	tobacco uae c	ontributa to	the cause	of death?
0	es met me de igned by the be detached by Physic									10	Yes 2□ No	3 ☐ Prob	ably 4	Unknown
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ion of	for the form	27. Manner of Death  1	28e. Date (Monition		28b. Time of Injury		8c. Injur Wor			28d. Describe				
5	Cert	3 ☐ Suicide 6 ☐ Could no determina	200. Flace	of Injury - At h	nome, farm, st	reet, factory	, office			28f. Location ( City or Tox		ber or Rurel	Route Nur	m <i>ber,</i>
	ne nospital in 24 hours he Funeral pietaly filled edical C		Physician: To the aminar: On the ba and man											(s)
-	within 2 To the comple	29b. Signature end title of certifier	Del			290	. Licens	e number			29d. Date sign	ed (Month, D	Day, Year)	
	6	39 Name and address of person wh	o completed ceus	e of death (Ite	m 23e) (Type,		).C.1	M.E.			Septemb	er 14	, 199	8
		Divid R F 31. Date filed (Month, Day, Year) SEP 2	owler	egistraf s Sign	111		St	reet,	Bal	timore,	Maryla	and 212	201	
	State Registrar	SEP 2	2 1998	1										

State Registrar



State of Maryland / Department of Health and Mental Hygiene

hysicia		1. Decedent's Name (First, Middle, L.	ast)	7.5				2. Dete of Dea	Reg. No.	Yeer	3. Time of Death
Medic		JAMES W.	MOSBY					AUGUST	Dey 17,	1998	2:100
amin	er	4e. Fecility Neme (If not institution, gi HEARTLAND NURS)		)			4b. City, Town, or		,		37
neral	-			ge (In yrs. las	st birthdev) If U	nder 1 Year			1	GOMER	
erai		407-64-5868 Usuei Residence of Decadent	1 <b>8</b> 0 M 2□ F	54	Yrs. Mon	ths Days	Hours Min		y, Yeer) 1944	Count	ece (Stete or Fore ry) KY
Ħ		10e. State 10b. County		10c. City,	Town or Location					10	ld. inside City Limi
11100	ctor	MD Princ	e George	I	andover						1 <b>2</b> Yes 2 □ N
200	Oire.	10e. Street end Number			10f	. Zip Code			10g. Citizen of	Whet Count	ry?
1	rai	6903 Taylor Str	1				784		United	Stat	es_
N I	by Funeral Director	11. Marital Status  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Yeer or Detes:	?			Hispenic Origin? (Seen, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		ce - America ck, White, e y: Bla	tc.
	Completed	15. Decedent's E (Specify only highest gr			16e. Decedent's U	Usuei Occup	petion during most of wo	rking	16b. Kind of B	usiness/indi	ustry
	mp.	Eiementery/Secondary (0-12)	College (1-4or	5+)			d)	rking			
		12th 17. Fether's Neme (First, Middle, Last	1		Prin	iter	40 44-4-4-11	Time At All	Privat		ustry
	Be C	Curtis Mosby						me (First, Middle,		10)	
	L L	19a. Informent's Neme/Relationship	Type, Print)		19b Meiling Add	ress (Street	end Number or R	hy Yates		State Zin /	Code)
		Evelina Mosby -					Street,				5000)
		20a. Method of Disposition			pe of Disposition (	(Neme of		Dete	20c. Location		m, Stete
OUCE.		1 XBunei 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Contro	Removei from Stete		lenwood	,		8/22/98	Washi	naton	DC.
- SOUCE		21. Signeture of Funerel Service Lice			22. Name	e end Addre	ess of Fecility				, DC
a	1	X 42.54	1				rton Co. on, DC 6				
al er	ner	Immediate Ceuse (Finei disease or condition resulting in deeth)		Due to (or e	otis Dis s e consequence Infarcti	of):					Years
	Examiner	Sequentieily list conditions,	b. Tiyocai		s e consequence					1	
		Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Olseese or Injury that initieted events	Diabet	es Me	llitus					1	
	n/Medical	thet initieted events resulting In deeth) Last	d	Due to (or es	s e consequence	of):					
	Sicia Sicia	Part II. Other eignificant conditione of	ontributing to deeth b	ut not resultir	ng in the underlyin	na ceuse aix	ven in Pert I	23h Did to	obacco use co	ntribute to	the cause of deat
	by Physician/N	Cerebral Vascul			- In the discony	ig oodso git			/ss 2□No	3 ☐ Probe	
	Completed							24e. Wes e	en autopsy med?	evei	e eutopsy findings leble prior to pletion of cause seth?
	5							1□ Y	es 2 No	1 🗆	Yes 2□ No
	Re	25. Wes cese referred to medical examiner?	Herebal.					eth (Check only or	ne)		
	0	1 Yes 2 No 27. Menner of Deeth	Hospitai: 1 ☐ Inpatie		VOutpetient 3□		4 LOS NUTSING P	lome 5 Resid	-		
	Certification:	1 Neturel 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b		y Year)	Bb. Time of Injury M	28c. Injur Wor 1 🗆	y et rk? Yes 2 □ No	28d. Describe h	ow Injury occur	red	
		4 ☐ Homicide determined	28e. Plece of Injude	ury - At home c. <i>(Specify)</i>	e, ferm, street, fac	tory, offica		28f. Location (S City or Tow		er or Rural i	Route Number,
	edical	29e. Certifier 1 X Cartifying Ph (Check only one) 2 Medical Exam	ysician: To the best of linar: On the basis of end manner ste	examination	dge, death occurr end/or investiget	red et the tin tion, In my o	ne, dete end plece pini <i>on</i> , deeth occu	, end due to the c rred at the time, d	euse(s) end me lete end piace,	nner es ste end due to t	ted. he ceuse(s)
		29b. Signeture end title of certifier									



State of Maryland / Department of Health and Mental Hygiene

09-5369-510	1					31	alt
98-5368-510 ITEM: #2	23	PART	I,	11,	27	PER	М
	1. De	cedent's	Nama	(First, M	iddla, L	.ast)	
Physician		Greg	ory	Co1	for	d Mu	rp

9. Birthplace (State or Foreign

White

10d. Inside City Limits

Approximata Intarvai Batween Onsat and Death

24b. Were autopsy findings available prior to complation of cause of death?

1 Vas 2□ No

1 → Yas 2 No

3:25AM

Examiner **Funeral** 

Director Directo Funeral py Completed

the Marylend

7 is marked other than "natural", or items 23s or 28a-f show traumstic event, the Medical Examinar must be nothed at with deeth permit. Pages 1 and 2 should be filed within 72 hours etter c. Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or tem eny lojury or other traumatic event, the Mental Exercises page.

altimore, Maryland 21215-0020

**Physician** /Medical Examine

Examiner ettending physicien and for use as the burial-transit requires that the death certificate be executed Physician/Medical 98 ed by the e signe A Completed peeu page 2 hes certificate Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica director, Be 2 funeral Certification: filled in by

Division of Vital Records, P.O. Box 68760

Certificate of Death Reg. No. 2. Data of Death Month Day SEPT. 12, 1998 hy 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2040 EAST PRATT STREET BALTIMORE Baltimore City If Undar 1 Yaar Months Days If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 39 Yrs. 15 M 20 F 216-76-8021 July 16, 1959 Massachuetts Usuat Rasidance of Decedan 10a Stata 10b. County 10c City Town or Location Maryland Baltimore City Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 2040 E. Pratt Street 21231 U.S.A. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11 Marital Status 12. Was Decedant Evar in U,S. Armed Forcas? Black, Whita, atc. 1 Yas 2 No if Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married 1 ☐ Yas 2 ☐ No Spacify: Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elemantary/Secondary (0-12) College (1-4or 5+) unknown unknown 18 Mothar's Name (First Middle, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Be Robert S. Murphy Diana Mary Hanlon 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Robert S. Murphy/father 436 Colonial Ridge Lane, Arnold, Maryland 21012 20b. Placa of Disposition (Nama of cematery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata 5 Othar (Spacify) 4 Donation 21. Signature of S <sup>22</sup> Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street narai Service Lie Ronald S. Wade | Director Baltimore, Maryland 21201 mulle BAITIMORE, MARYLAND 21201

and Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Immediata Causa (Final disaasa or condition rasulting in daath) RHEUMATIC MITRAL VALVE DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Causa (Diseasa or Injury that initiated events rasulting in death) Last Dua to (or as a consaquance of): Dua to (or as a consequence of)

25. Was case referred to medical axaminar?

1XX as 2 No

27, Manner of Death

1 Natural

2 Accident 3 Suicida

4 \ Homicide

(Check only one)

29a, Cartifian

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

STATUS POST LIVER TRANSPLANT

28a. Data of tnjury (Month, Day Year)

24a. Was an autopsy

26. Place of Death (Check only ona) Other: 4 Nursing Homa SOR Residence 6 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 28b. Tima of 28d. Dascribe how injury occurred 28c. tnjury at Work? 1 Yes 2 No

111 Penn Street, Baltimore, Maryland 21201

6 Could not be detarmined 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Spacify)

28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

Additional Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

2 No

1 Yas

29b. Signatura and titla of certifier

5 Panding invastigation

29c. Licansa number O.C.M.E

29d. Data signed (Month, Day, Year) SEPT. 15, 1998

23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown

30. Name and address of person who completed causa of death (tam 23a) (Type, Print) Chute, mo

DennisJ

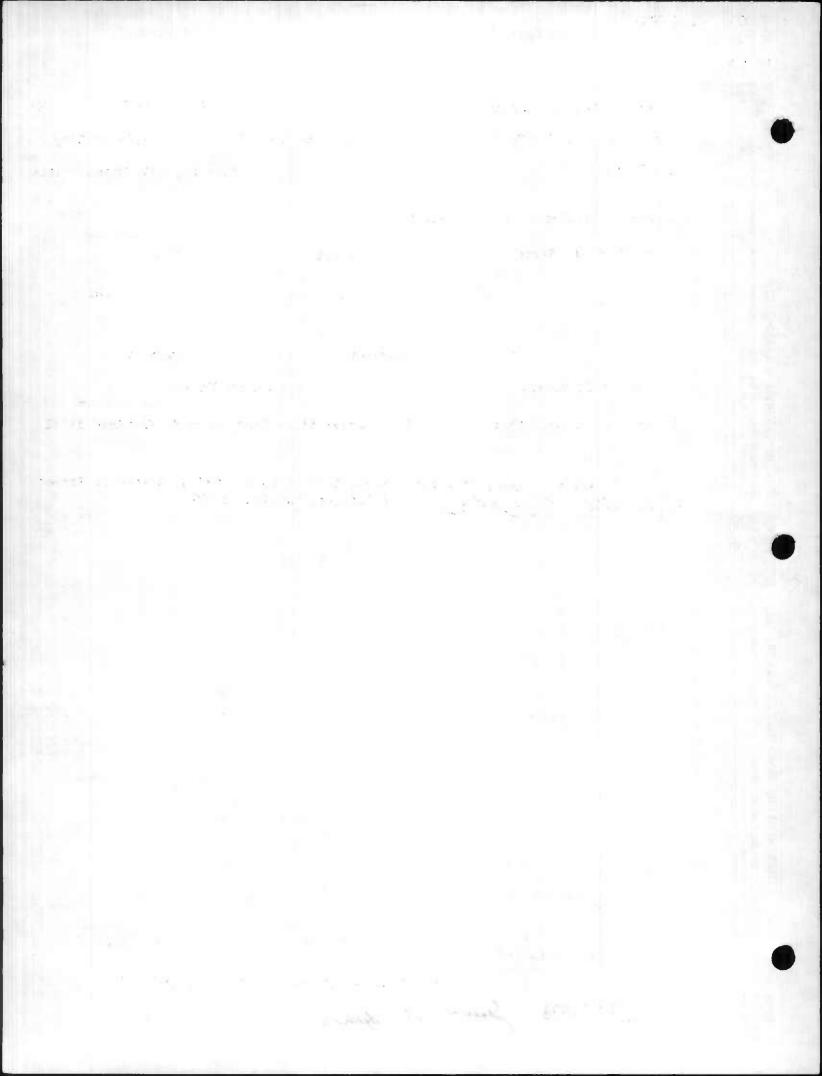
32. Registrar's Signatura

State Registra

24 hours

To the Hosp within 24 hou To the Funer completely fil

edical



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** NICCLEN 5:194.m. SEPTEMBER /Medical 4a Facility Name (Il not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ospita Baltimore Kins ohn HOP If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) Funeral Montha Days -4728 1 M 200 F 216-54 Director **Uaual Residence of Decedent** 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examinal must be notified at 1 Yes 2 No saltimore Director am NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 USA PP16 GOT death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Merital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hydiene. Important: if Item 27 Is marked other than "natural; or Nem any injury or other traumatic event, tra Medical Expension Black, White, etc. 1 Never Merried 2 Merried Baitimore, Maryland 21215-0020 1□ Yes 2NNo Specify þ 3 Widowed 4 Novorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Eder 160 2+1 17. Father's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) 19a. Informant's Name/Reletionship (Type, Print) 19b. Melling Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 200. Place of Disposition (Name of comeley, cremetory or other place)

Dete Balto Md. 21217 lacqueline Mclendon-Dava 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Cemetery 14-23-98 4 Donation 5 ☐ Other (Specify) Hone Arundel ar 22. Name and Addrass of Facility
Harch Funkral
4300 Wabash ature of Funeral Service Licensee Hom 21215 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. Approximeta Intarval Between Onset and Death **Physician** -MBOLISM /Medical Immediata Cause (Finel disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentially tist conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that in its agents of the cause (Disease or Injury) Due to (or as e consequence of) ettending physician and for use as the burnetier Division of Vitai Records, P.O. Box 68760 that initieted events resulting in death) Last Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tohacco use contribute to the cause of death? signed by ti 1 Yes 2 No 3 Probably 4 Unknown þ should I 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed

25. Was case referred to medical examiner? Hospital: 1 Yes 2 No 1 Inpatient 28e. Date of Injury (Month, Day Year) 28b. Time of

27 Manner of Death 1 Swatural
2 Accident 5 Pending investigation 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 28c. tnjury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Deeth (Check only one)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Yown, State)

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifie

sted cause of death (Item 23a) (Type, Print)

29c. License number

WOLFE STREET, BALTIMORE, MARY LAND

29d. Date signed (Month, Day, Year)

1 Yea

has

certificata

8

Certification: To

edical

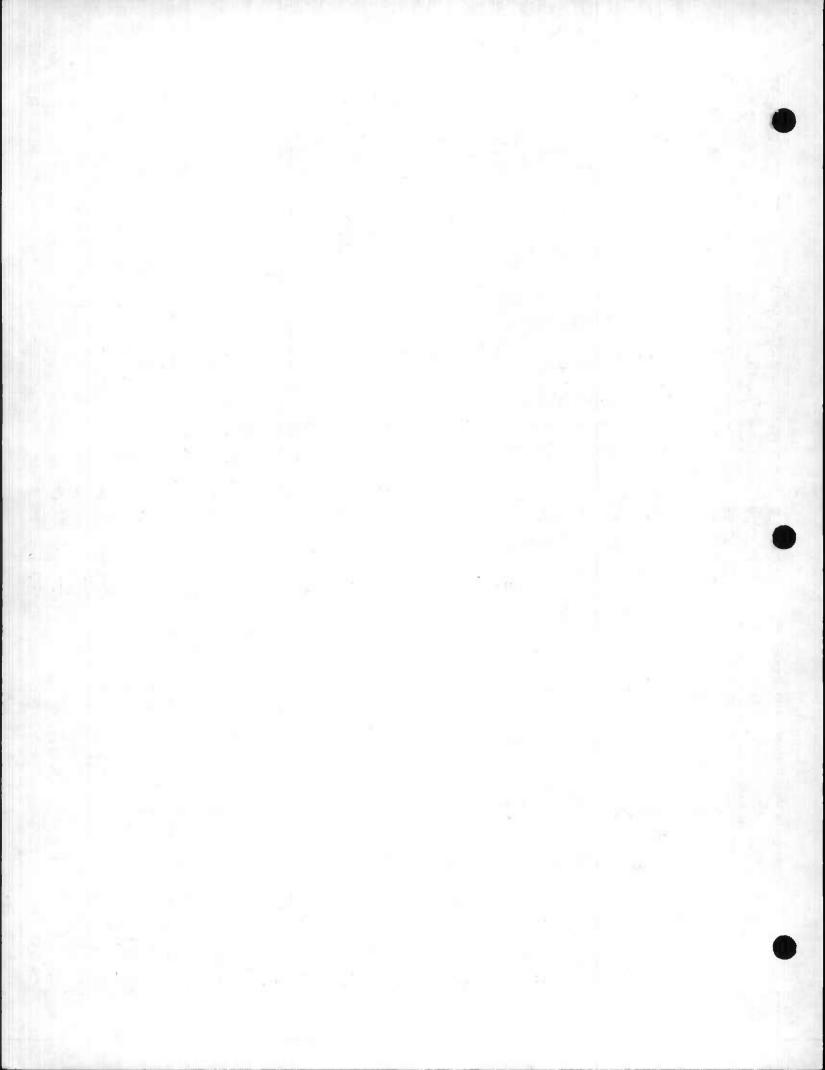
To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certific; completely filled in by the funeral director,

State Registrar

31. Date filed (Month, Day, Year) SFP 2 2 1998

00 NORTH 32. Registrar's Signaftin



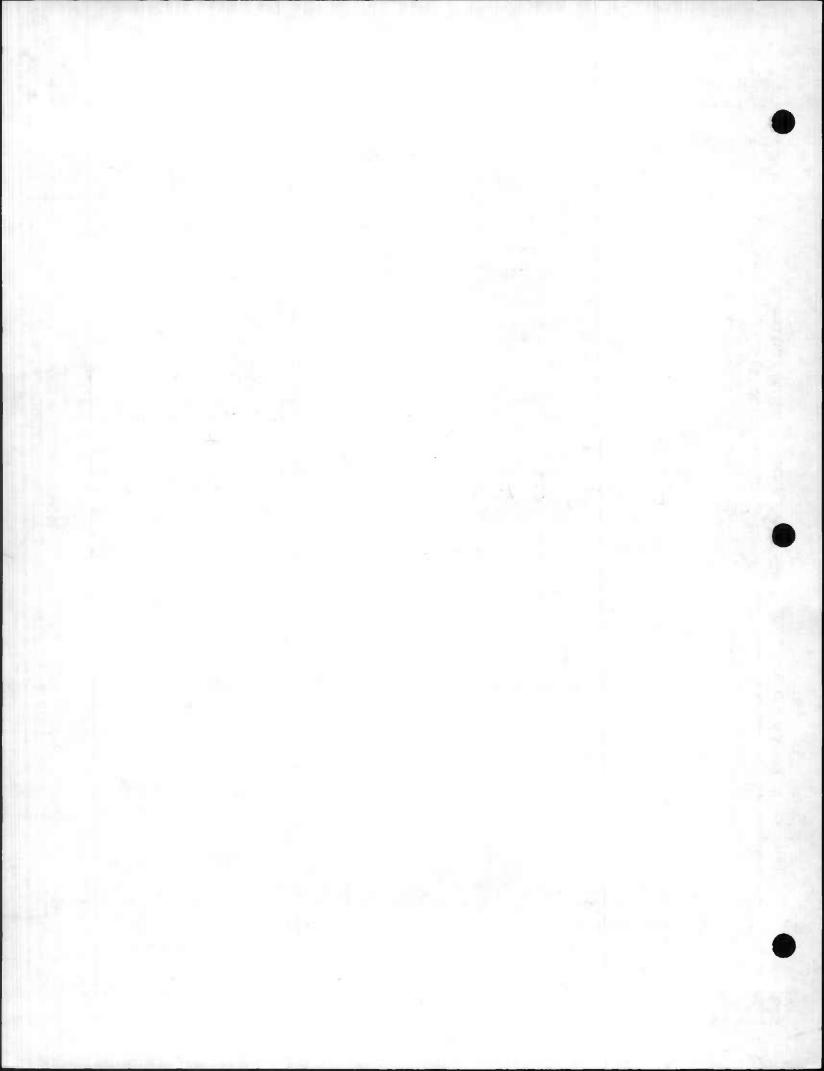
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Physician Month Harvey A. Mellott, Jr. 1998 Aug. 31 1:15 PM /Medical 4e. Fecility Neme (If not institution, give street and number) 4b City, Town, or Location of Deeth 4c. County of Deeth Examiner Avalon Manor Health Care Center Hagerstown Washington 7. Age (In yrs. last birthday) H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 77 Yrs. Months Deys Hours Min. 5 / 7 / 1 1 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** 1⊠M 2□F 183-12-1922 Director Penna. Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Director Franklin Penna. Ft. Loudon 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò items 23a 12807 Main Street 17224 USA Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?

1 □ Ves 2 □ No
If Yes, Give
Yeer or Detes: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-lif Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1 Never Merried 2 M Married Baltimore, Maryland 21215-0020 Specify:White "natural", or 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming 12 marked other 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Pages 1 end 2 should be 1 nent of Health end Mental Harvey A. Mellott, Sr. Minerva Walker 19a. Informent's Name/Reletionship (Type, Pnint) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Health end: If item 27 is no other traur Mrs. Betty M. Mellott/wife 12807 Main St., Ft. Loudon, Pa. 17224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Sept. 1 XBurial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Stenger Hill Ceme. 3,1998 Ft. Loudon, Pa. 21. Signature of Funer 22. Name and Address of Fecility
Lininger-Fries Funeral Home ion Licente 23a. Pert1. Enter the disease, or complications that cause the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 47 N. Park Ave., Mercersburg, Pa. 17236 Approximate Intervel Betw Onset end Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Pheumonia 3 - 4 work Examiner Due to (or es e consequence of) Physician/Medical Examiner Anter is relentic Ca 70 be executed iclan and buriel-trans Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Lest Due to (or es e consequence of): nding physician a Box 68760. The law requires that the death certificate Due to (or es e consequence of): P.O. Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Chronic Reme 1 Yes 2 No 3 Probably 4 thknown Distritos Mellitas signed be del Records, à 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? page 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Vital Be 25. Wes case referred to medical 26. Plece of Death (Check only one) Other: 4 Sharsing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 € No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA o 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. fnjury et Work? 28b. Time of 28d. Describe how Injury occurred Division or Attending 5 Pending Investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours e To the Funersi C completely filled Hospital edical 29a. Certifier 1 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) end menner as steted.

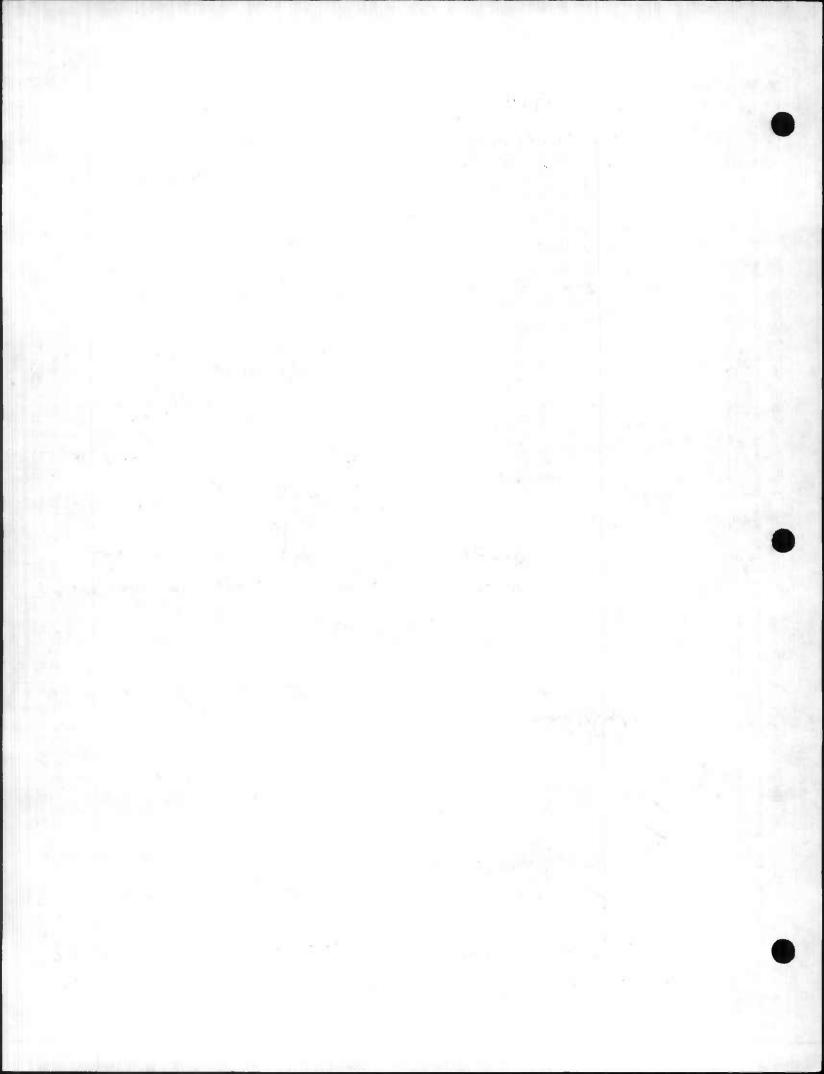
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) end manner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (2na ~0 Ans 31, 1998 018017 30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print) Vasant Datta, M.D. 334 Mill St., Hagerstown, Md. 31. Dete filed (Month, Day Year) 2 2 1998. Registrer's Signeture State Registrar

			Item#20b per	FH G763		larylan		tificate of	Health and N Death		giene Reg. No. 98	2	8895
	Physiciai /Medica	1	1. Decedent's Nama (F ANTHON	A STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STA						2. Data of De Month SEPTEME	Day	Year 998	3. Time of Death 12:05 PM
	Examine	_	4a Facility Nama (# no 1210 CZ			)			4b. City, Town, or L BALTIMORE		h 4c. County N/.		
	Funeral Director		5. Social Security Num 215-10-733	37	Sex 7. A	ga (In yrs. 83	last birthday) Yrs.	If Under 1 Yaar Months Days		8. Data of Bir (Month, Da May 14	th. Year) 1915	Coun	olaca (Stata or Foreign oltry) Land
	how			b. County			y, Town or Loc					1	Od. Însida Cîty Limits
	or 28s-fa	2	Md .	n/a		Ba	TTIMOLE	10f. Zip Code			10g. Citizen of t	What Cour	1 Yes 2 No
4	23a or		1210 Ca		Street				230	13.5	USA	What Cour	my r
020	permit. Taggs I and 2 should be lied within 72 hours are death with the waryand Depertment of Health and Mentel Hyglane. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic avant, the Medical Evant for must be notified at once.	5	11. Maritat Status  1 Never Married  3 Widowed 4	111111111	12. Was Deceden Armed Forces 1  Yas 2 If Yas, Giva Year or Dates:	?	If	Vas Decedent of Vas, specify Cub	Hispanic Origin? (Sp an, Mexican, Puarto Specify:	ecify Yas or No Rican, atc.)	Blac	e - Amaric ck, Whita, v: Whi	atc.
121	and Montal Hygians, and Montal, is an annual in marked other than "natural", raumatic avant, tre Medical English	niplete.			ducation ada completed) College (1-4or	5+)	(Giva I lifa. D	ent's Usuai Occu kind of work dona O NOT use retire Bundery	during most of work d)	ing	16b. Kind of B		
	Mental Hygi mrked other atic avant, in	2	17. Father's Nama (Fire Ignatius		"				18. Mother's Nam Joseph	a (First, Middle ine Gio		na)	
2 3	Health and Ment		19a. Informant's Name Constance			ce)			court,Li	nthicum	, Md. 2		Code)
ore	ment of He ant: If Itan ury or oth		20a. Mathod of Disposi 1 Burial 2 DO 4 Donation 5	remation 3	Removat from State	0	st Holy	sition (Nama of latory or other pla Y Redeem		ept: <del>23</del> 1998	DOLLOTINO		
Ball	Department of Important: If any Injury or page.		21. Signature of Funar	Tere,	D. Dir	Mez	227	Name and Addre MCCully— 130 E. F	Polyniak ort Ave.	Funeral Baltimo	Home ore, Md.	2123	80
	hysician		23a. Part1. Enter the c shock, or heart te	lisaasa, of con iliura. List only	nplications that cause ona causa on aach	d tha deat ina.	h. Do not anta	r tha moda of dy	ng, such as cardiac	or raspiratory a	rrast,	1	Approximata tntarval Batween Onset and Death
	/Medical Examiner		immediata Causa (Findiseasa or condition rasulting in death)	ai	a				retal co	mar			Syrs.
3	3 %				h	Dua to (o	or as a consequ	Jance or):				1	
58760,	physiciant and the burial Hansit		Sequentially list condit if any, taading to imme cause. Entar Underlyin Cause (Disease or injuthat initiated events	ions, diata ng ny	c		or as a consequ	210.00					
. Box 68760,	attending phy		rasulting in death) Last	l	d	Dua to (o	r as a consequ	ence of):					
D. B	d by the attending letached for use as		Part ii. Other significar	nt conditions	contributing to death I	out not rase	ulting in the un	darlying causa gi	ven in Part i.	23b. Did	tobacco uae co	ntribute to	the cause of death?
P.O.	90									10	Yes 21 No	3 Prol	bably 4 Unknown
Records,	hould		420							24a. Was	an autopsy ormed?	av	ara autopsy tindings ailable prior to mpletion of cause death?
- F	cate has									10	Yas 2 No	10	Yas 20M6
of Vital	s certificate director, pag		25. Was casa ratarred axaminar?	to medicat	Hospital:	-nt 20	ER/Outpatient	20 DOA 01	26. Place of Deat		ona) dence 6 □Oth	· · · · · · · · · · · · · · · · · · ·	. 4
C 8	ther th	-	27. Manner of Death  1  Natural 5 2  Accident 3  Suicide 6	Pending invastigatio	28a. Data of Inj (Month, De	iry Year) jury - At ho	28b. Tima of tnjury	28c. Inju	4   Nuising Fic	28d. Dascribe	how injury occur	red	ul Routa Number,
Div	ins after lied in b		4 Homicide	Jataninino	building, a	c. (Specify	y)			City or To	wn, Stata)		
H ad	within 24 hours after death. To the Funeral Director: A completely filled in by the fi		29a. Certifier 1 (Check only one)	Certifying Pt Medical Exa	nysician: To the best miner: On the basis of and manner s	f axaminat	tion and/or invi	astigation, in my	opinion, daath occur	red at tha tima,	data and place,	and dua to	tha cause(s)
1	Toth	1	29b. Signatura and titla	of certifiar	_ 40			29c. Licen.	se number		29d. Data signe	d (Month,	Day, Year)
	6	3	30. Name and addrass				23a) (Type, F	Print)	UC VAI		2010	3.15	2 6
	State Registrar	3	31. Data filed (Month, E		32. Regist		900 C	Ann.	SE BALI	MIRE	han	012	-9



State of Maryland / Department of Health and Mental Hygiene 3 28896

				C	ertificate of	Death	R	eg. No.	20000
ysician		. Decedent's Name (First, Middle, La	st)	0	1111/13		2. Date of Dea Month	Dev '	3. Time of Death
ysician Medical	_	Jesse 1	Yallins	Sr			Septemb	er 19,19	198 4:30 A.
aminer	0.0	Facility Name (If not institution, giver Harbor Hosp					Location of Death	4c. County of	Death
		•			If Under 1 Yea		ore City	N/A	
r		213-28-6420	x 2 F 77	n yrs. last birthda Yrs.	Months Day			1921	9. Birthplace (State or Foreig Country) Virginia
		Isual Residence of Decedent  Oa. State 10b, County	10	Oc. City, Town or	Location				10d. Inside City Limits
5		Maryland N/A	1.0	Baltimo					1X Yes 2 □ No
Director	10	0e. Street and Number 3923 Inner Cir	cle		10f. Zip Code	21225	1	0g. Citizen of Wi	net Country?
Funeral	Ē .		12. Was Decedent Eve	-1-110	No. Deceded of		2		- American Indian,
2	6	1. Marital Status  1. Never Married  Married  3. Widowed 4. Divorced	Armed Forces?  12 Yes 2 No If Yes, Give Year or Detes: 1		3. Wes Decedent of If Yes, specify Cu 1 ☐ Yes 2X No.		rto Rican, etc.)		White, etc.
Completed	2	15. Decedent's Ed (Specify only highest gra		16a. Dec	cedent's Usuel Occ	upation	odkina	16b. Kind of Bus	iness/Industry
TOK	Ž -	Elementary/Secondary (0-12)	College (1-4or 5+)	1	ve kind of work don . DO NOT use retir				
ပ္ပ	5	12	0	Ret	ired US A	, ,	and distance a distance of		vernment
To Be	n	7. Fether's Neme (First, Middle, Last) Henry	Mullins			Verda	me (First, Middle, i	Kilgore	
	1	9a. Informant's Name/Relationship ( Catherine June Mu	***		eiting Address <i>(Stree</i>				
		Oa. Method of Disposition		20b. Place of Dis	position (Neme of				ity or Town, State
		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removel from State	Greenmou	nt Cem. C	rematory	9/21/98	Baltimo	ore, Maryland
	2	1. Signeture of Funeral Service Licer	See Kevin E.	Ecker	22. Name and Add		7 7 11		
		XUL			McCully-P 237 E. Pa	tansco A	-uneral H	omes o Md	21225-1856
	2	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	death. Do not e	enter the mode of d	ying, such as cardia	c or respiratory arr	est,	Approximate Interval Between
in									Onset end Death
al -	d	mmediate Cause (Finel lisease or condition	100-to	M	YXCC	nolia	J to	done	tien
ſ	r	esulting in death)	Acote	e to (or as a cons	seruence of):		2 .		7 ,
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Examiner	S	sequentially list conditions,	U	e to (or as a cons					
		sequentially list conditions, any, leading to immediate ause. Enter Underlying cause (Disease or injury	XYAR	ren	0000				
edicai	5 th	hat initiated events esulting in death) Last	Due	to (or as a cons	equence of):				
3	2		d						
Completed by Physician/	5								İ
ysk	P	art II. Other significant conditions of	ontributing to death but n	ot resulting in the	underlying cause of	given in Pert I.			ribute to the cause of deat
4		Emphysen	-er				104	es 2 No	3 Probably 4 Unkno
Q P	3	, )-					24a, Wes a	n autopsv	24b. Were autopsy tinding
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ပို							1 🗆 Y		1 ☐ Yes 2 ☑ No
Be	3	E Was and salamed to medical				Whor	eth (Check only or		
0	25	5. Wes case referred to medical axapmer?	Hospital:				Home 5 Reside	ence 6 LiOther	
10	25	axapmer? 1 ☐ Yes 2 ☐ No	1 ∐ Inpatient	2 PER/Outpet	ient 3LI DOA		28d. Describe h	ow injury occurre	1-1
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** MEYER MAZER SEPT. 18, 1998 3 PM /Medical 4b, City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOSPICE OF BALTIMORE - GILCHRIST CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT 5, 1918 Sex 1XXM 2□ F 7. Age (In vrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Yrs. NEW YORK 110-05-0897 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A BALTIMORE 1XX yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be a 21208 7219 PARK HEIGHTS AVE.; APT. 205 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1XX es 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 200 Married 1 Yes 2XNo Specify: WHITE py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) REAL ESTATE 12 BROKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SAMUEL B. MAZER SARAH BEREZOFSKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health If Item 27 IRENE MAZER / WIFE 7219 PARK HEIGHTS AVE, APT.205; BALTIMORE, MD 21208 20a. Method of Disposition
1 ☑ Perial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State Pages 8 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON CHIZUK AMUNO 9-20-1998 BALTIMORE, MD 21. Signature of Funeral Service Licansee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD; PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. **Physician** Large cell Ly in phone Due to (or as a consequence of): /Medical Immediate Cause (Final disease or condition resulting in death) years Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 88 US8 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 3 Probably 4 Unknown 1 Yes 2 No signed t PV 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Tother (Specify) Hospice To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? After Certification: or Attending 1 Natural
2 Accident 5 Pending after death. Director: Aft 1 Yes 2 No Investigation 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical To the Hosp within 24 ho To the Fune completely f (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cegifie 29c. License number , mo 30. Name and address of person who comp cause of death (flors ) (Type, Print) N. Charles St. Bolts. md 2120x Rilay 6704 31. Date filed (Month, Day, Year) 32. Aegistrar's Signature SEP 2 2 1998 Registrar



# Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Film G763 9-2	22-30KC			Ce	rtificat	te of L	Death			Reg. No.	70	4	0000					
	_	1. Decedent's Name (Fir.	st, Middle, Las	nt)	1						2. Dete of De Month	eth Day		Year	3. Time of E					
hysician /Medical	_	RAYINI	ONIO		MIC	HAE	15				SEPT	19	19	198	104					
xaminer		la Facility Name (If not in 1442 BUCK)			ber)			4		wn, or Li	ocation of Deet LLE	4c. C	CA1	f Death RROLI						
ineral rector	2	5. Social Security Number 213–82–14		9x 7		lest birthdey)	Months Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, De JULY 2	y, Year	30		ace (Stete or stry) RYLAND					
	-	Usual Residence of Dece																		
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death sept. **Physician** 20, 6:45pm Vera Margaret Muntean /Medical 4c. County of Death 4e Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner Knollwood Manor Millersville
r If Under 24 Hrs. 8. Da
s Hours Min. (M. Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 TE 217-07-4897 87 Director Sept. 20,1911 Maryland Usual Residence of Decedent 10d Inside City Limits 10a State 10h Count 10c City Town or Location r 28a-f ahow 1 Yes 2 No Director Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be a USA 487 Greenwood Street Funeral 21113 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 No
If Yes, Give
Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 Yes 2X No Specify: Specify White þ 30Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "n any Injury or other traumatic event, the Heal once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 07 Own Home 18. Mother'a Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be Corry Stater Estella Leopold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rhoda A. Reynolds - Sister 487 Greenwood Street, Odenton, MD 21113 Baltimore, 20b. Placa of Disposition (Name of cametery, crematory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removel from State 9/23 4 ☐ Donation 5 ☐ Other (Specify) Epiphany Episcopal Cemet Odenton, MD 21. Signature of Funeral Service Ligensee 22 Name and Address of Fecility Hardesty Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

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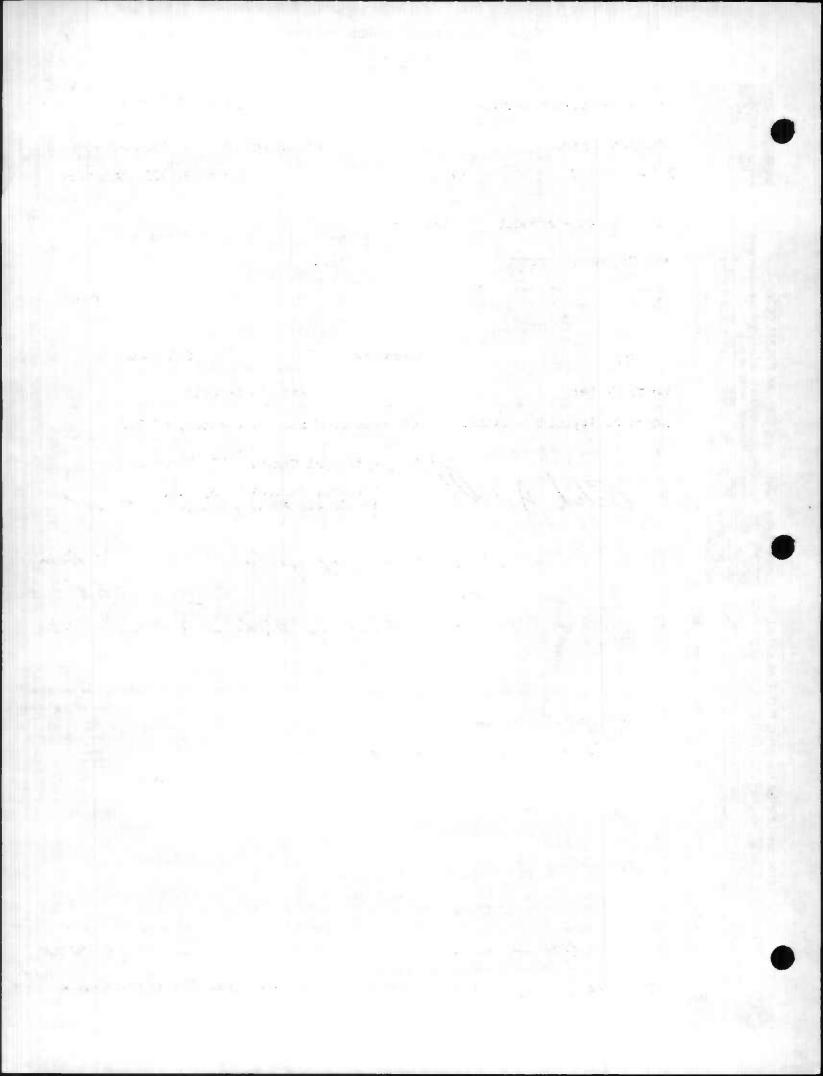
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Approximate Approximete Interval Between Onset end Death **Physician** /Medicai Immediate Cause (Final disease or condition resulting in death) aleite Asspiratory failes va Examiner Examiner Duelo (or as a consequence of): physician and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Advanced AlZheimers disease your Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a conseq signed by the a Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Hyperteniin 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Completed Covoring Arteny disease certificate has blinector, pege 2 s 1 ☐ Yes 2 KNo 1∏Yes 2∏No or Attending Physician: 25. Was case referred to medical exeminer? 28. Place of Deeth (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending after death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide A 24 hou. Hospital to the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner es stated.

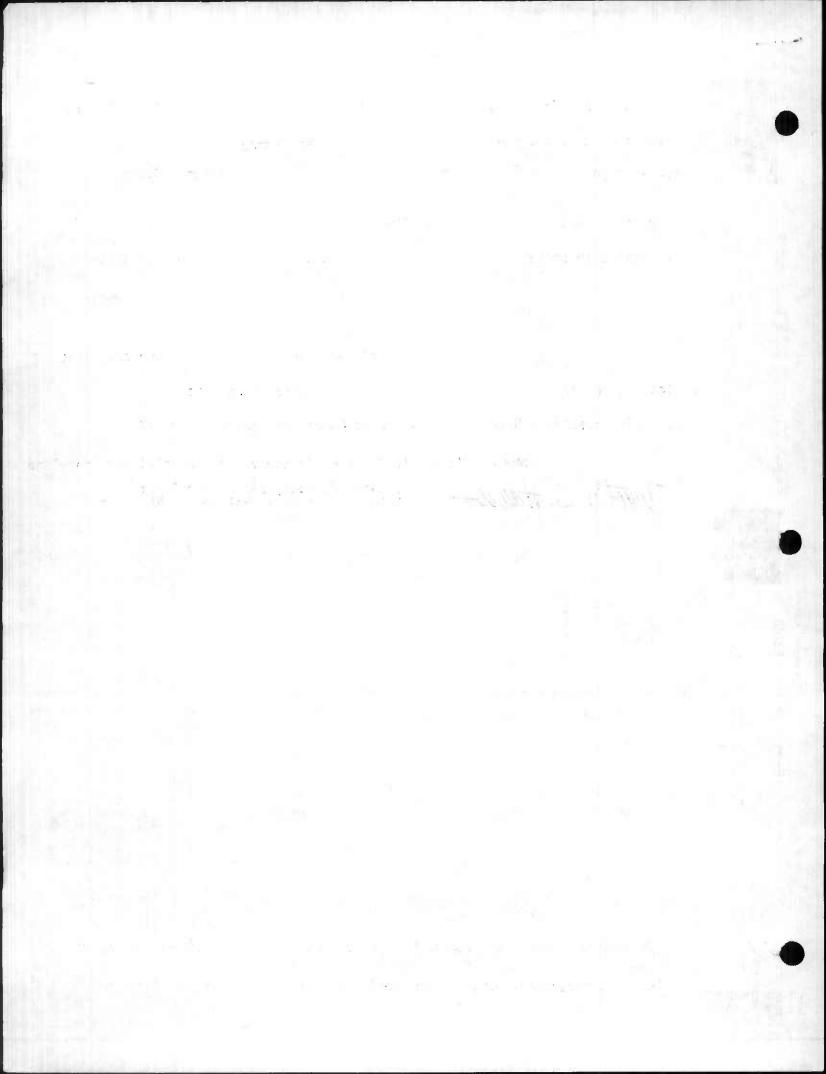
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, end due to the cause(s) and menner stated. edical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number 125000 1,10 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 1916 Crain Huy, Sw. # f Glen Burnie 4514 Hung M P 32. Registrar's Signeture 31. Date filed (Month Day Yées) 2 1998 State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** 6.00 Pi7 CONSTANCE MORINI SEPTEMBER 19 1998 /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Keswick Multicare Center Baltimore N/A Hours | Min. | 8. Dete of Birth | 9. Birthplece (State or Foreign | 1903 | Virginia | 1903 | Virginia 5. Sociel Security Number 6. Sex If Under 1 Year **Funeral** 7. Age (In yrs. lest birthday) 1 □ M 2X F Deys Yrs. 94 Director 218-70-7034 Usuel Rasidence of Decedan the Maryland 10a. Stete item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic svent, the Wedical Examiner must be notified at 10b County 10c. City, Town or Location 10d. inside City Limits 1 XYes 2 □ No Director Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 110 West 39th Street 21210 United States deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ DNo If Yes, Give Yeer or Detes: 11. Maritel Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indien, Bieck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: White 3 Widowed 4 □ Divorced "natural", Completed Decedent's Usuei Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grede completed) permit. Pages 1 and 2 should be filed within 72. Department of Heelth and Mentel Hygiene. Important: If flam 27 is marked other than "natt any injury or other traumatic avent, the Medica once. 16b. Kind of Business/Industry Elemantary/Secondery (0-12) Coilaga (1-4or 5+) 12 Owner/Proprietor Grocery Store 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Be Nicholas Failla Rosa Camaratta 19e. Intorment's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. Louis Mazzulli / Nephew 4 Erwood Court Baltimore, MD 21212 20b. Plece of Disposition (Name of cemetery, cramatory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetton 5 MOther (Specify) Entombment Most Holy Redeemer Cemetery 9/23/98 Baltimore, Maryland 22. Name end Address of Fecility Leonard J. Ruck, Inc. Funeral Home Talla 5305 Harford Road Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart to are. List only one cause on each line, **Physiclan** /Medical Immediete Ceuse (Final Metastatic breast cancer 21/2 years disease or condition resulting in deeth) Examiner Physician/Medical Examiner Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in daath) Lest Due to (or es e consequence of): Box 68760. physician Due to (or es e consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse givan in Pert I. 23b. Did tobacco use contribute to the cause of death? advanced demention and hinter t ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, by 24b. Ware autopsy findings eveileble prior to completion of ceuse of daath? Completed 24a. Was en autopsy performed? of strakes 1 ☐ Yes 2 D No 1 ☐ Yes 2 ☐ No Division of Vital al or Attending Physician: T s efter deeth. I Director: After this certificat of in by the funeral director, p 25. Wes cese referred to fiedical exeminer? Be 28. Placa of Death (Check only one) Hospitei: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 280 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 27. Menne of Deeth 28e. Dete of injury (Month, Dey Yeer) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturei 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be data mined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicide To the Hospital or A within 24 hours efter To the Funeral Directompletely filled in by 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, date and piece, and due to the ceuse(s) end menner stated. Medical (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) Mabelle has 30. Name and eddress of person who complated cause of deeth (Item 23e) (Type, Print) Isabelle MacGregor, M.D. 700 West 40th Street Baltimore, Maryland 31. Dete tiled (Month, Day, Year) SEP 2 2 1998 State Bower as Registrar



State of Maryland / Department of Health and Mental Hygiene

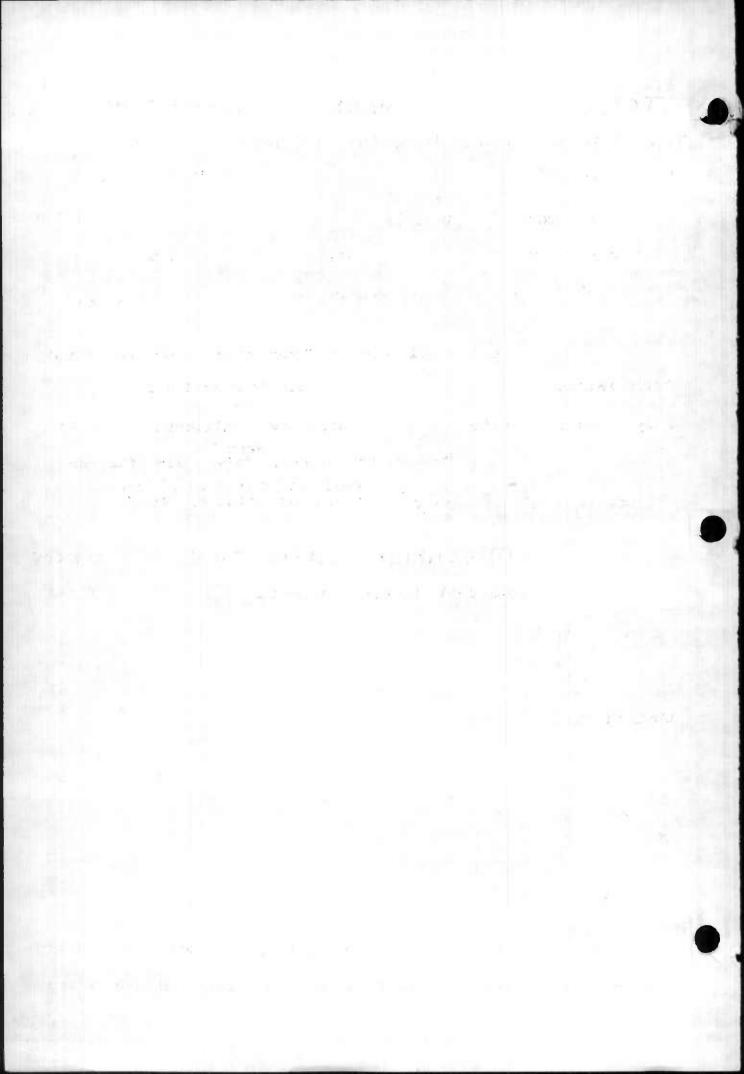
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Month September JOHN MARRON 11:0 4b, City, Town, or Location of Deeth 4c. County of Death 4e Facility Neme (If not institution, give street end number) Baltimore HOPKINS 7. Age (In Johns HOSDITA If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number 6. Sex Birthplace (Stete or Foreign Country) neral Days 180 M 2□ F 76 169-12-9621 ector Dec 19 1921 Ireland Usual Residence of Decadent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 Yes 2 No Baltimore Director MD Dundalk 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7604 Meadow Way 21222 USA 12. Was Decedent Ever In U,S. Armed Forces? 1 ★Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Merried 2 ☑ Married 1 Yes 2 No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Director of Recreation Baltimore County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) James Marron Winifred Faulkner 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary J. Marron /wife Baltimore, MD 21222
Dete 20c. Location - City or Town, Stete 7604 Meadow Way Sept 21 20a. Method of Disposition 20b. Plece of Disposition (Neme of cametery, crematory or other place) 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. 1998 Timonium, MD 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility
Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 23a. Pert1. Enter the disease or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL IN FARCTION ONE DAY niner LORONARY ARTERY YEARS DISEASE Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Lest Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yes 2 No 3 Probably 4 Unknown UROSEPSIS þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Piece of Deeth (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) '9b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) SEPTEMBER 17, 1998 Ouzemore MO RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAY SIZEMORE, JOHNS HOPKINS HOSPITAL 110 TOWER BALTIMORE, MD 31. Date filed (Month, Day, Year) SEP 2 2 1998 32. Registrar's Signature

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Registrar

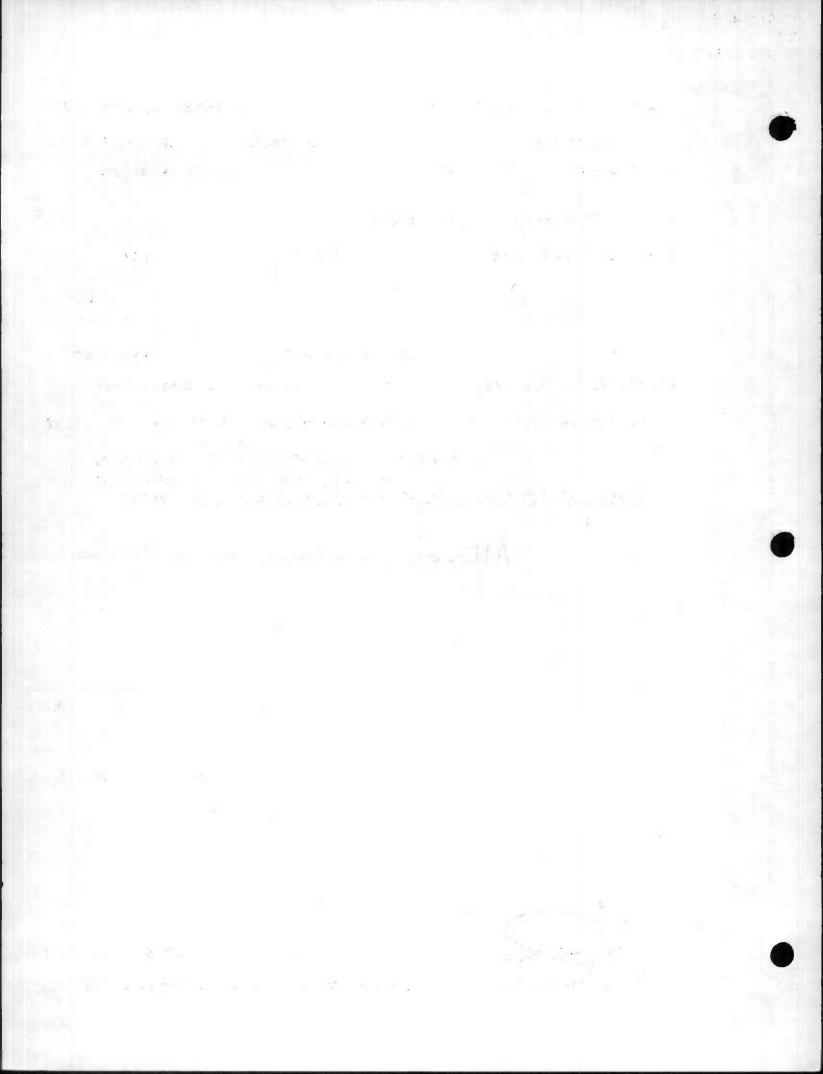
Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

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State Registrar		EP 2 2 199		recent	1							
Registrar	9	PI ~ 10 133	10 /-	1	D.	Ana.	11					

Registrar DHMH 16 Rev 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle Last) 2. Dete of Deeth **Physician** Month September 18,1998 4b. City, Town, or Location of Death 4c. County of Death Louis Paul Meninger /Medical 4e. Facility Name (If not institution, giva straat and number) 4c. County of Daath Examiner Fallston General Hospital Fallston Harford If Undar 1 Yaar If Undar 24 Hrs. Months Deys Hours Min. 5. Sociel Security Number 6. Sax 1 M 2 ☐ F 8. Date of Birth (Month, Dey, Year) Feb.8, 1917 7. Age (In yrs. lest birthday) Birthplece (Steta or Foreign Country) **Funeral** Deys 217-01-9438 Yrs 81 Director Baltimore, Maryland Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No Directo Marvland Baltimore Fork 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 12519 Regwood Road Funeral 21051 U.S.A. 12. Was Decedant Ever in U.S. Amped Forces? 1 (2/Yss. 2 □ No 1943 If Yes, Give Yaar or Datas: 10/24/45 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - Amarican Indian, Bleck, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yas 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 4yrs. n/a Carpenter Independent Self/Emp 17. Fether's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Louis Meninger Mary Reihl 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 4035 Federal Hill Rd. Jarrettsville, Md. 21084 Mrs.Theresa Baynes (Daughter) 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Highview Memorial Grds. 9/21/98 Fallston, Md. 21047 21. Signetura of Funaral Service Lice 22. Name end Address of Fecility E. F. Lassahn Funeral Home 01 11750 Belair Road Kingsville, Md. 21087 23a. Part1. Enter the disaesa, or complications that ceused the death. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset and Deeth Immediate Cause (Final diseese or condition resulting in deeth) tive minutes Physician/Medical Examiner ten years omyopath Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence Due to (or es a consaquance of): Part II. Other significent conditione contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 3 ☐ Probably 4 Unknown 1 Yes 2 No Completed by 24b. Were eutopsy findings eveileble prior to complation of ceusa of deeth? 24e. Wes en eutopsy performed? 2 No 1 ☐ Yes No 25. Wes case referred to medicel exeminar? Be 28. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation Naturel

The law requires that the death certificete be assocuted P.O. Box 68760, of Vital Records, funeral

nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland armonent of Health end Mental Hygiene. ordant: if item 27 le marked other than 'netural', or items 23s or 28s-f show injury or other traumatic event, me Mencal Examinating the netting at

Department of Important: If any injury or

**Physiclan** /Medical

Examiner

Baltimore, Maryland 21215-0020

Certification: To Division or Attending efter deetl Hospital of 24 hours e Medical

LOUIS

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within 2

Certifying Phyeicien: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner steted. 29b. Signeture end title of certifian 29c. License number 29d. Date signed (Month, Dey, Year)

30. Neme end eddress of person

1 TYes 2 TNo

September 18, 1998

28f. Location (Straat and Number or Rural Routa Number, City or Town, State)

(Item 23e) (Type, Print)

Belair Maryland 21014 Nost Avenue 31. Dete filed (Month, Day, Year)

State Registrar

6 Could not be determined

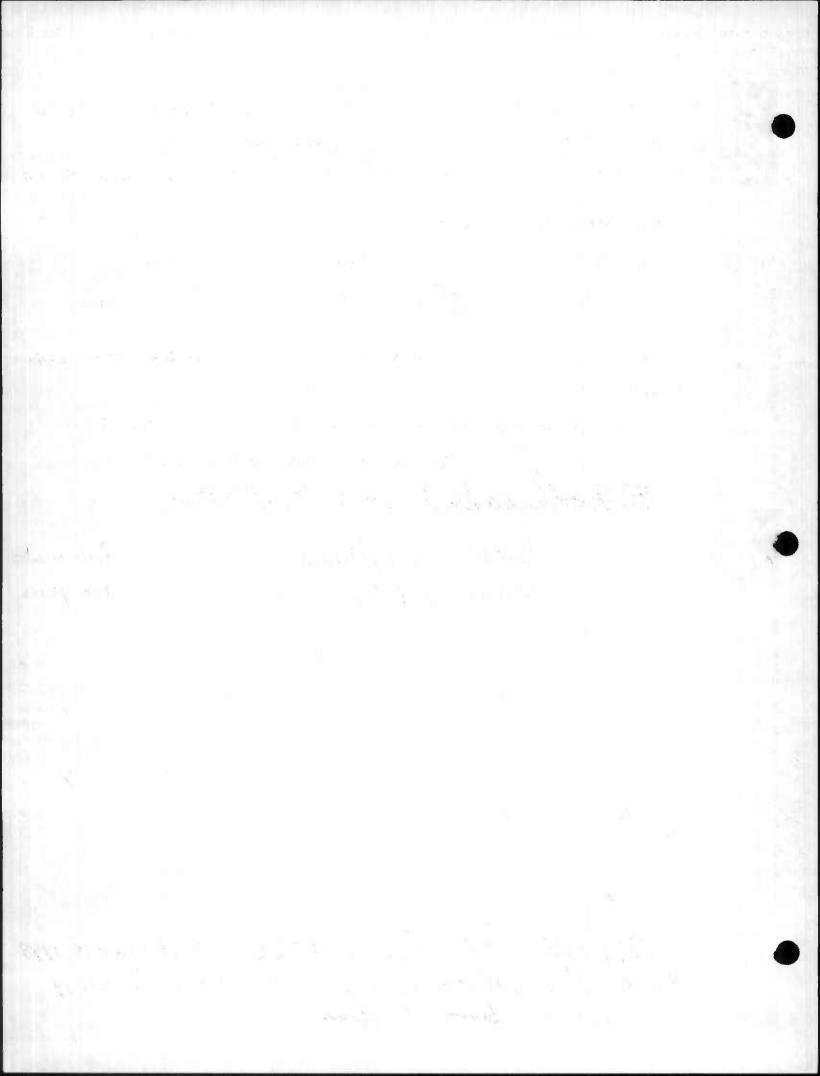
2 Accident

3 Suicide

29e. Certifier (Check only one)

4 T Homicide

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Andrew Kristian Ness Sept.19, 1998 11:20am 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death 425 Schley Road Annapolis Anne Arundel If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Deys Hours Months 089-14-2079 1 M 20 F 75 Yrs. Dec.17,1922 New York Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No MD Anne Arundel Annapolis 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 425 Schley Road 21401 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status Yes 2 No 1 Never Married 25 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Mechanical Engineer U.S. Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Albert C. Ness Emma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Dorothy Rhoads Ness- Wife 425 Schley Road, Annapolis, MD 21401 20h. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 9/22 Crownsville, MD 22. Name end Address of Fecility 21. Signature of Funeral Service Ligenses Hardesty Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory effect, shock, or heart failure. List only one cause on each line. agail Approximate Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) ymphocytic Leukemia Due to (or es a confequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2) No 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one)

**Physician** /Medical Examiner

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**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

"natural", or items 23a or 28a-f show

other treumstic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours aftar nent of Haalth and Mental Hygiene. nt: If Item 27 le marked other than "natural", or fre

Baltimore, Maryland 21215-0020

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death v

The law requires that the death certificate be executed signed by t been si cartificata To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: Aftar this cartifica completaly filled in by the funeral director, I

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical by Completed Be

Certification: To

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(Check only one)

State Registrar

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Injury at 28d. Describe how injury occurred 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Netural 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier

29b. Signature and little of certifier

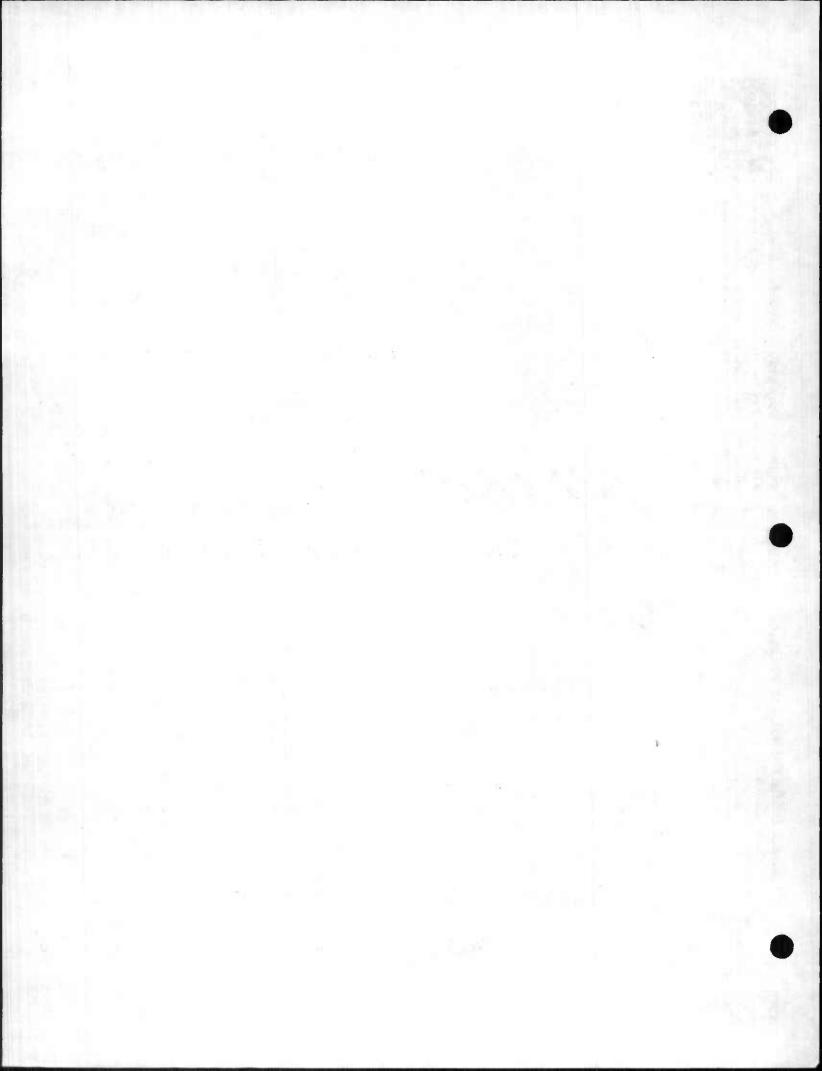
29c. License number

29d. Date signed (Month, Day, Year)

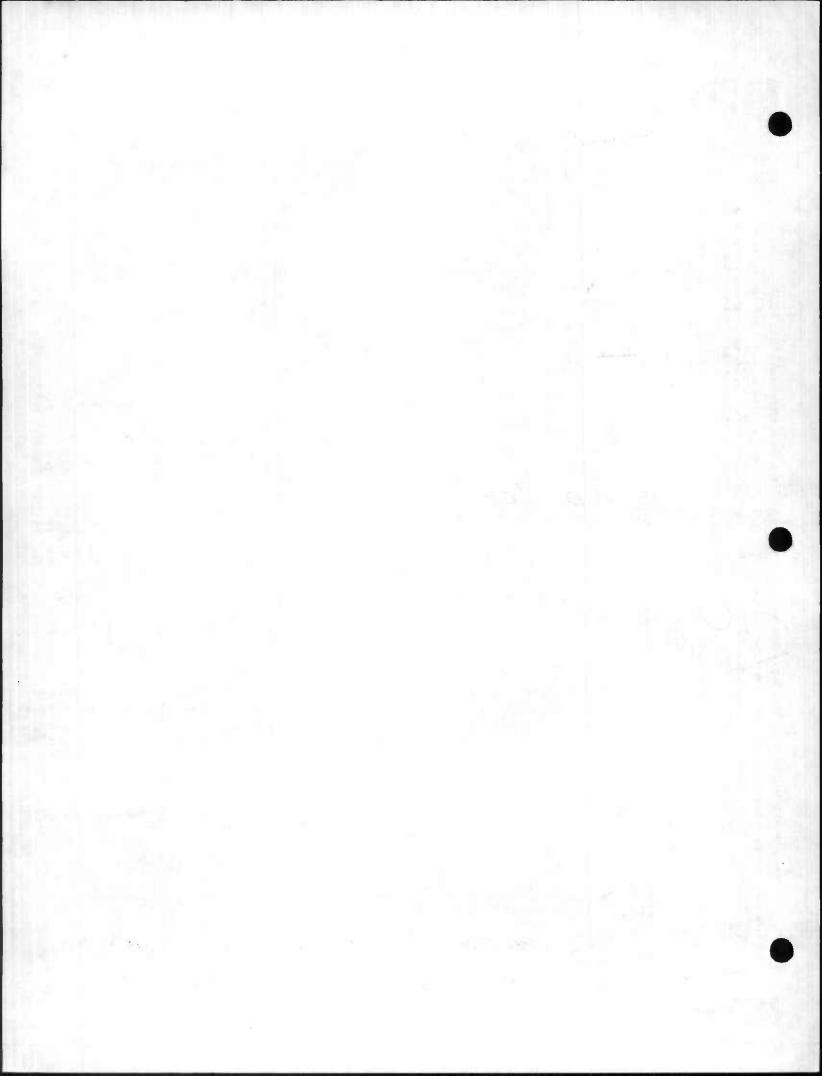
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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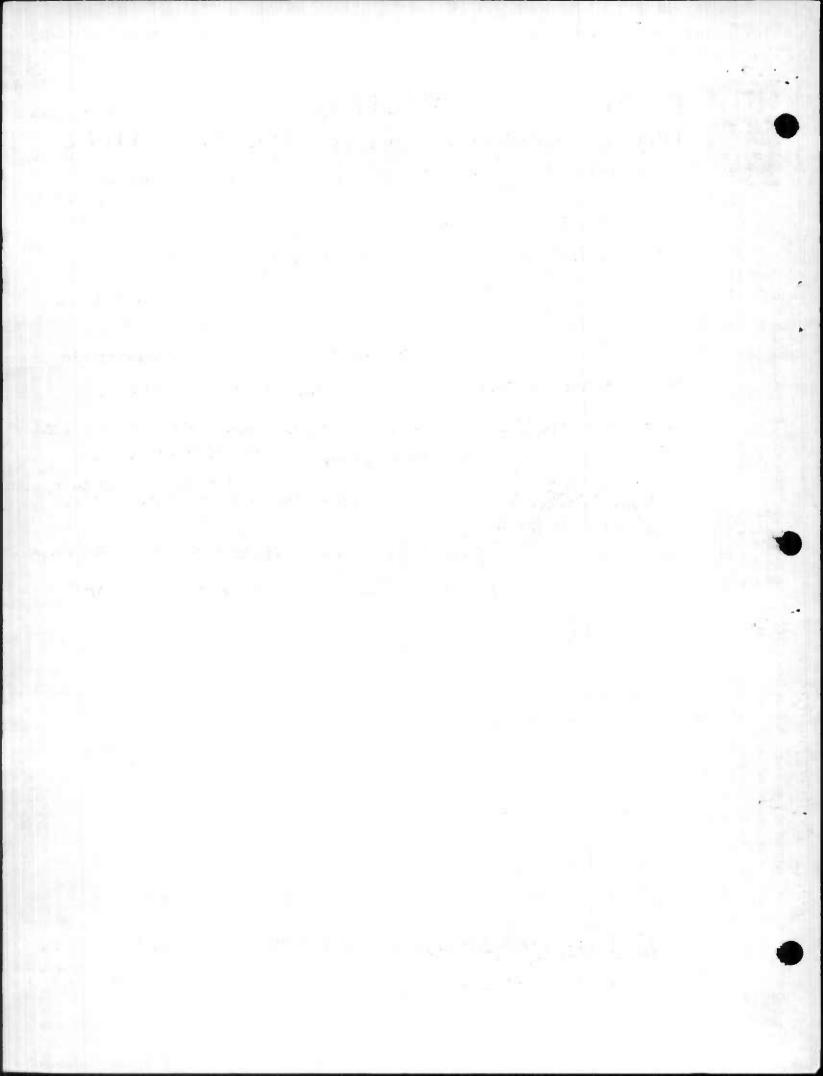
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Amend: #15 Pe	r FH Film G763 9-22-98R	State of Mar		rtment of F tificate of		Mental Hy	giene Reg. No.	28905
Physician /Medical	1. Decedent's Name (First, Middle, La JOHN T. OWENS	st)				2. Deta of De Month SEPT.	Day	3. Tima of Death 998 7:45 P.M.
Examiner	4a Facility Name (If not institution, giv GOOD SAMARITAN		ITED		4b. City, Town, or BALTI		4c. County of	
Funeral Director	5. Social Security Number 6. S 217-09-9056		In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th y, Year)	9. Birthplace (Stata or Foreign Country) MARY LAND
/land	Usual Rasidance of Dacedent 10a. Stata 10b. County	1	Oc. City, Town or Lo	cation				10d. Inside City Limits
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with the Ma a or 28a-f s be notified	10e. Street and Number	reture		10f. Zip Code	010		10g. Citizen of Wi	
E 23 E	3417 WOODSTOCK AV	12. Was Decedent Eve	ar in U.S. 13. V		213 fispanic Origin? (5	Specify Yes or No		S. A American Indian,
15-0020 72 hours after dea *natural; or forms filted Exemple: m	1 Nevar Married 2 Married 3 Widowed 4 Divorced	Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas:		Vas Decedent of I Yes, specify Cub ☐ Yes 2 ※ No	an, Mexican, Puer Specify:	to Rican, etc.)	Black Specify:	WHITE
Maryland 21215-0020 d.2 should be filed within 72 hours after than and Mental by Uppiene. The merked other than natural; or for traumatic avent, the Mental Earthin To Be Completed by Fu	15. Decedant's Ec (Specify only highast gra Elementary/Secondary (0-12) Unk.	lucation da complated) Collega (1-4or 5+)	eation during most of wo d)	rking	16b. Kind of Bus	ING COMPANY		
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altimore, mit. Pages 1 an partment of Haa portant: If Item 2 y Injury or other 28.	20a. Mathod of Disposition		20b. Place of Dispos	sition (Nama of		Date		City or Town, Stata
Page ment of lury or lury or	1					9/21/98	BALTIMOR	E, MARYLAND
Baltirr pemit. Pa Department Important: any Injury pace.	21. Signatura of Funaral Sarvice Licen  Buin a	willen	S	CHIMUNEK	FUNERAL	HOME IN	NC. ORF MARV	'IAND 91913
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O. B. o death he attorned for sicia	Part II. Other significant conditions of	ontributing to death but n	not resulting in the un	derlying cause giv	ren in Part I.	23b. Did	tobacco use cont	ribute to the cause of death?
	DEHYDR	ATION				10	Yes 2000	3 Probably 4 Unknown
Vital Records, idean: The law requires the cartificate has been signe rector, page 2 should be to Be Completed by							an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?
Com Cont				CRED HEART OF JESUS  22. Nama and Address of Facility SCHIMUNEK FUNERAL HOI 3331 BREHMS LANE, BA  th. Do not enter the mode of dying, such as cardiac or res  or as a consequence of):  or as a consequence of):  utting in the underlying cause given in Part I.  26. Place of Death (Ch	10	Yes 2000	1 Yes 2 No	
	25. Was cesa rafarrad to medical axaminar?	Hospital: 1 ☐ Inpatiant	аПспо-т-нісь	Ott				(0
Division of an article of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	27. Mapnar of Death 1 SNatural 5 Panding 2 Accident Invastigation	28a. Data of Injury (Month, Day Y	28b. Time of	28c. Inju	y at/		how injury occurre	-
Divis	3 Suicide 6 Could not be determined	28a. Place of Injury building, etc. (	- At home, ferm, stre Specify)	et, factory, office		28f. Location ( City or To	Street and Number wn, Stete)	r or Rural Routa Number,
Hospi 24 hou 24 hou Funar cely III	(Check only 2 Medical Examone)	yelcian: To the best of milner: On the basis of ax and mannar steted	amination and/or Inv	occurred at the tir estigation, in my o	me, data and place pinion, deeth occ	e, and due to the urred at the time,	cause(s) and man date end place, ar	ner as stated. nd due to the cause(s)
To the within 1 To the comple	29b. Signature and title conflier	and	1	29c. Licens	396	7	9-10	(Month, Day, Year)
2	30 Nama and addrass of person who cessor G-G	completed ceusa of dast	th (ttem 23a) (Type, I	3440	BELA	in A	BAT	TO MINES
State Registrar	31. Date filed (Month, Day, Xear 1998	32 Registrar's		Sparks	,			



· · _ I	em#23b,24a per Phy G763			ent of Health and ate of Death	Re	g. No.	28906	
Physician /Medical	1. Decedent's Name (First, Middle, Last ARTHUR	Pr	TULI	P5	2. Dete of Death Septem	ser / /	Year 2000	
Examiner Funeral Director	Social Security Number 6. Se	SENSIAL	HOSPI last birthday) If Unc Yrs. Month	TAT FAL der 1 Year If Under 24 H	in. (Month, Dey,	4c. County of HAC		
A 10	Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Location			.0 1	10d. Inside City Limi	
r 28a-f show	MD Baltimo	ore pa	arkville				1√2 Yes 2□1	
r Hems 23e or 25a-f s river maint by noutled	10e. Street and Number			Zip Code	10	g. Citizen of Wh	nat Country?	
e 23e	8328 Hillendale	PROAD  12. Was Decedent Ever in U.		21234-5004		JSA	A	
2	11. Marital Stetus  1 □ Never Married 2 □ Married  3 ₩ Vidowed 4 □ Divorced	Armed Forces?  1 ☐ Yes XIXNo If Yes, Give Year or Dates:	If Yes, sp	cedent of Hispanic Origin? cecify Cuban, Mexican, Pu 2 Nox Specify:	erto Rican, etc.)		- American Indian, , White, etc. V h i t e	
event, the Medical Be Completed	15. Decedent's Edu (Specify only highest grad	icetion le completed)	16a. Decedent's Us (Give kind of the	work done during most of v	vorking 1	6b. Kind of Bus	iness/Industry	
vent, the Me	Elementery/Secondary (0-12)	College (1-4or 5+)	Bus I	use retired) Oriver		Mass w su		
event, t	17. Father's Name (First, Middle, Last)		Dus L		leme (First, Middle, M		portation	
	Martin Luther I	Phillips		Mary I	Florence	Robin	nson	
traumatic	19a. Informant's Name/Relationship (T)	/pe, Print)	19b. Mailing Addre	ess (Street and Number or	Rural Route Number,			
other	Leighton H. Phi  20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	kville Oc. Location - C Vhite H	e, MD 2123 Eity or Town, State Hall, MD					
any injury or one	21 Signature of Funeral Service Licens 23a. Pert1. Enter the disease, or compleshock, or heart failure. List only or	tolar	24 9	second St.,	New Fre	edom.	Mortuary	
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for use es	•	d						
Physician/M	Part ii. Other significant conditions cor	ntributing to death but not resu	ulting in the underlying	cause given in Part i.	23b. Did tot	pacco use cont	ribute to the cause of dec	
be deteched by Physic					1 □ Ye	1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Un		
2 should pieted					24a. Was an perform	autopsy ed?	24b. Were autopsy findin aveitable prior to completion of cause of death?	
Com					1 □ Ye	s 2 No	1 ☐ Yes 2 ☐ No	
director,	25. Was cese referred to medicei examiner?	lospital:		Other	eath (Check only one			
E 785	27. Manner of Death	28a. Date of injury	28b. Time of	DOA 4 Nursing 28c. Injury at Work?	Home 5 Resider			
d in by the funer entification:	1 Natural 5 Pending investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No				
≥ a	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	28f. Location (Str. City or Town,		r or Rural Route Number,			
complataly filled in	29a. Certifier 1 Certifying Physical Check only one)	sicien: To the best of my knowner: On the basis of examinat	viedge, death occurre ion and/or Investigation	ed at the time, date and pla on, in my opinion, deeth oc	ce, and due to the ca curred at the time, da	use(s) and man te and place, ar	ner as stated. nd due to the cause(s)	
compla	29b. Signature and title of contiller	and manner stated.	2	9c. License number	29	d. Date signed	(Month, Day, Yeer)	
0	> Restate.	Valarao	MO.	0/6389	2	, 0		
	30. Name and address of person who co	ompreted ceuse of deeth (item	23e) (Type, Print)	- 1716 HARFE	SPP EP Ru	1061	en 1, (990) = ALLSTON M	
State	31. Date filed (Month; Day, Year) SFD 2 2 190	32. Registrar's Signat	ture &	1 .				

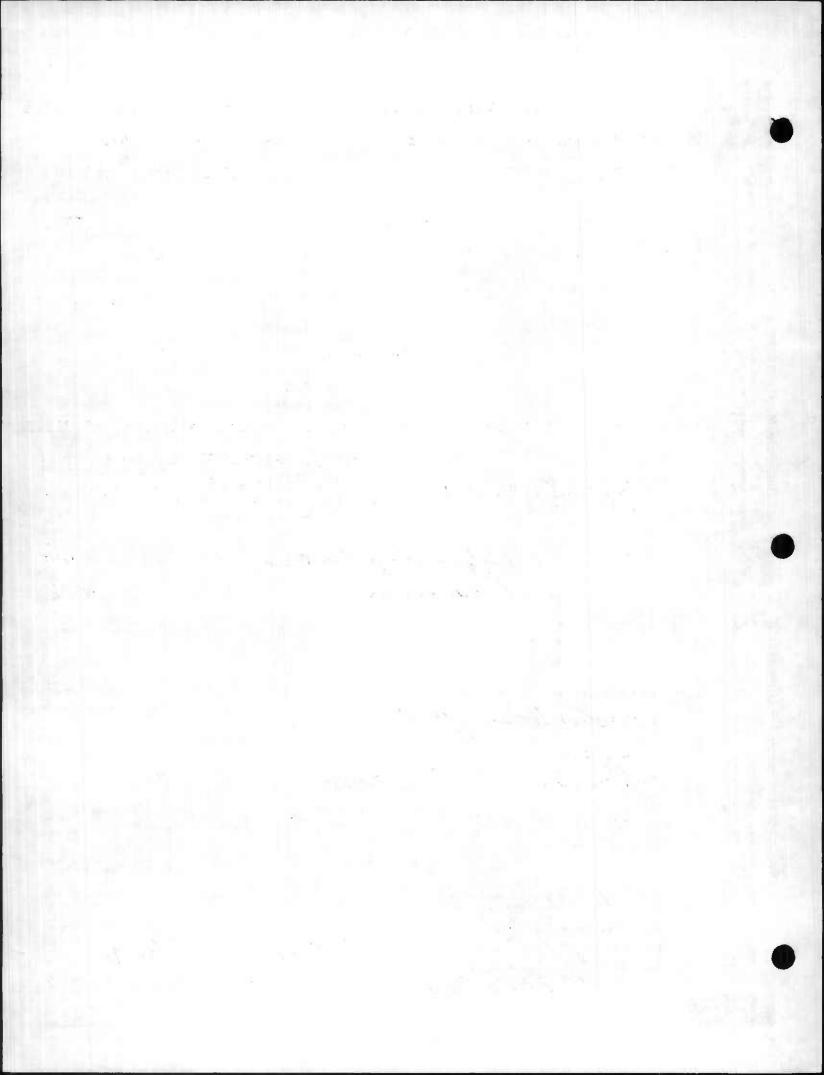


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Dete of Death **Physician** 20, 3:45pm Margaret Virginia Peters Sept. 1998 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not Institution, give street and number) 4c. County of Deeth Examiner Irvington Knolls Care Center Baltimore Hours Min. 8. Dete of Birth (Month, Dey, Year) AUG 13, 19 If Under 1 Yaar 5. Social Security Number Birthplaca (Stete or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** 1□ M 2₩ F Months Deys 217-54-3816 89 Yrs 1909 Maryland Director Usuel Residence of Decedent the Marylend 10e. Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1X Yas 2 No Director MD N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 7 is marked other than "naturel", or items 23s or traumatic event, the Maxical Examiner must be a 22 S. Athol Avenue 21229 USA permit. Pages 1 and 2 should be filed within 72 hours eftar death v Depentment of Health and Mental Hygiena. Important: If Item 27 is marked other than "naturel", or items 234 any injury or other traumatic event, the Medical Expenses mans Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexicen, Puerto Rican, etc.) 14 Bace - American Indian Bleck, White, etc. 1 Naver Merried 2 Married altimore, Maryland 21215-0020 1 Yas 2 XNo Specify: þ 3 Widowed 4 Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Meiden Sumema) 17. Fathar's Nama (First, Middle, Last) Be UNK. Hickman IINK. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 400 Rosecroft Terrace Baltimore, MD 21229 of Disposition (Name of Date 20c. Location - City or Town, State Laura Hartel / Daughter 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Crametion 3 ☐ Removel from State Metro Crematory, Inc. 9/21/98 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Cremation Society of Maryland, Inc. 21. Signeture of Funeral Service Licens 299 Frederick Rd. Baltimore, MD 21228 Dawn F. McDonald

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical fmmediete Ceuse (Final diseese or condition resulting in deeth) Scralau Examiner Due to (or es e consequence of) Examine Due to (or es e consequence of) Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in death) Last P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were eutopsy findings available prior to completion of ceuse of deeth? 24e. Wes en autopsy performed? Completed certificata has b director, paga 2 s 25. Wes case referred to medical exeminer? 2 No 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this certifical letely filled in by the funeral director, Be 26. Piece of Deeth (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Neturel 2 Accident 5 Pending 1 Yes Investigation 6 Could not be determined 28a. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) and menner as stated.

Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi edical (Check only one) 29b. Signatura and titla of certifian 29c. License number 29d. Date signed (Month, Dey, Year) OL 30. Neme and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) 2717 Hammonds Ferry Rd. Baltimore, MD 21227 MAG 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State SEP 2 2 1998 Registrar



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dafa of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) PINNOCK 4b. City, Town, or Location of Death 3 AZTIV Facility Neme (If not institution, giva street end number) MERC MEDICAL CENTER BATIMORE IMORE CIT 8. Daia of Birth (Month, Dey, Yeer) 6. Sex 1 M 2 ☐ F if Under 1 Year If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiece (Stete or Foreign Country) Deys 13 Months UNK BALTIMORE, Usuel Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No MARYLAND BALTIMORE 10f. Zip Coda 10g. Citizen of Whet Country? 10e. Streef end Number USA 4506 GARRISON BLVD. 21215 12. Wes Decedent Ever in U,S. Armad Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Black, White, etc. Navar Merriad 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 XNo Specify: Specify: AFRO. AMERICAN 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) UNK UNIC 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) **GLENSTON** PINNOCK LOUISE BROWN 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) LOUISE BROWN MOTHER 4506 GARRISON BLVD, BALTIMORE, MARYLAND 21215 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Remove from State 4 Donetion 5 Other (Specify) 9/17/98RANDALLSTOWN, MD. KING MEMORIAL PARK 21. Signeture of Funerel Service Licensee LL OYD M. ESTEP ESTEP BROTHERS FUNERAL SERVICE, P. A. 1300 EUTAW PLACE, BALTIMORE, MD. 21217 Part 1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. 22. Name end Address of Fecility Approximete Intervai Between Onset end Death EMIC ENCEPHALOPATHY Immediate Cause (Finel disease or condition resulting In deeth) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceusa (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Dua fo (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 | Yes 24b. Were eutopsy findings eveileble prior fo 24a. Wes en eutopsy performed? completion of cause of deeth? 2 No 2 No 25. Was case referred to medical axaminar? 28. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Apatieni 1 Yes 2 No 2 ER/Outpetient 3 DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show

r than "naturel", or items 23s or the Medical Examiner must be a

permit. Pages 1 and 2 should be filed within 72 hours after death vacantment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or thems 234 any injury or other treumstic event, the Medical Examples master.

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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Examiner Physician/Medical by

signed by the a s certificate hes b director, page 2 s this

funeral After or Attending r death. efter deat Director: n 24 hours after dea ne Funeral Director nletely filled in by th

Completed

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Certification:

Medical

Division of Vital Records, P.O. Box 68760,

To the Hosp within 24 hor To the Fune completely fi

Pert II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I.

28e. Date of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 28b. Tima of 28c. Injury et Work? 5 Pending investigation 1 TYes 2 No

27. Menner of Deeth

1 Netural

2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street end Number or Rural Route Number, City or Town, State)

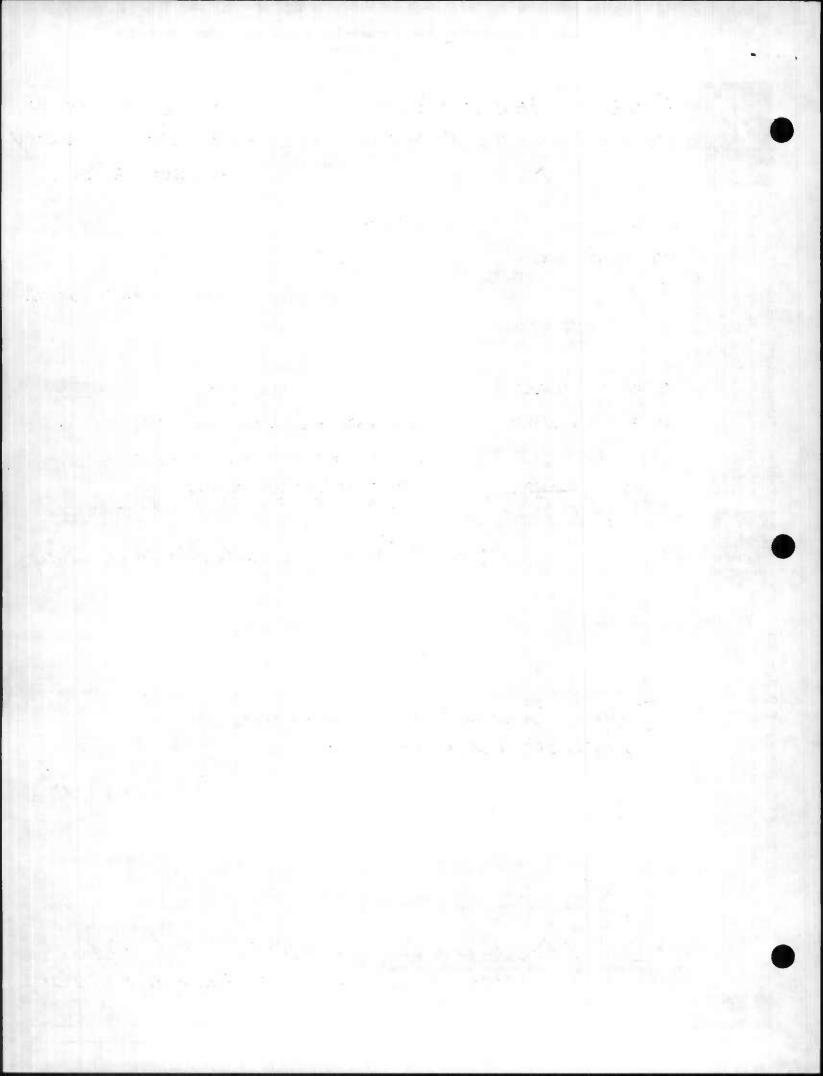
29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. odical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifian 29c. Licanse number 29d. Date signed (Month, Day, Year)

30. Neme end eddress of person who completed gause of deeth (Item 23e) (Type, Print)

DULKERIAN, M.D. J.

301ST PAUL PLACE BAITIMORE, M.D. 21202 31. Daie filed (Month, Day Year) SEP 2 2 1998 32. Registrar's Signature

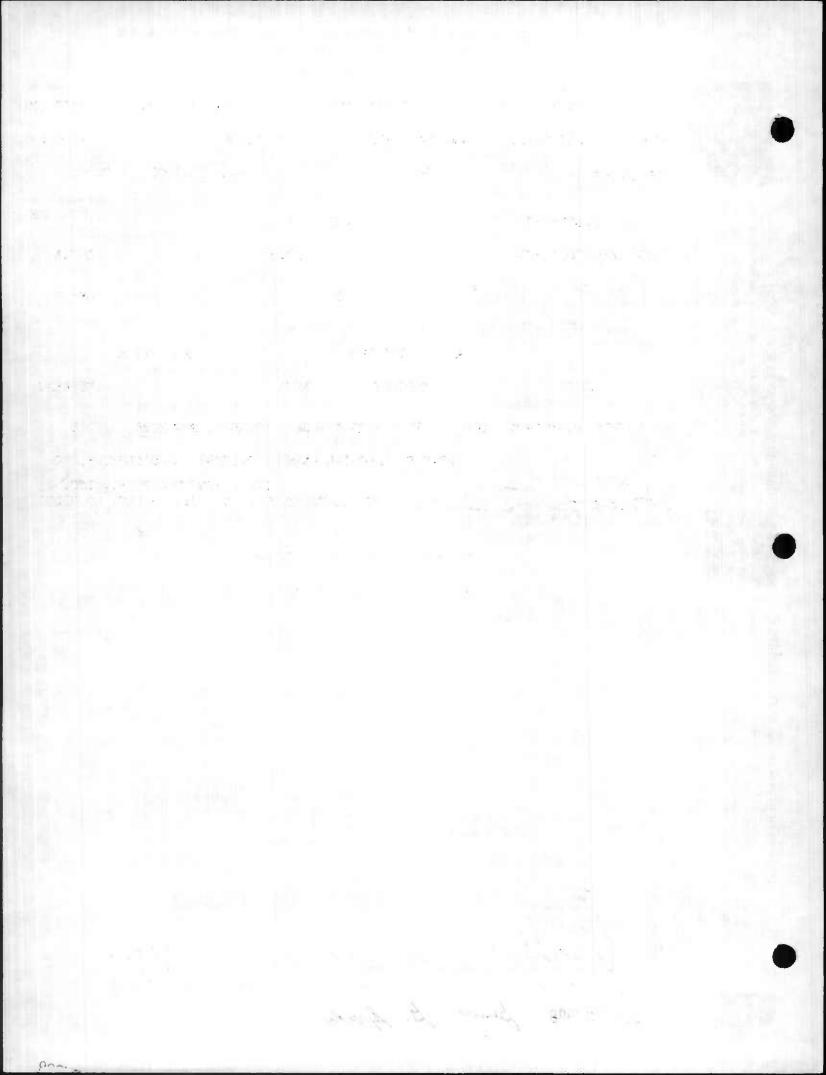
Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month SEPT. 16, 1998 **Physician** JENNIE **POMERANTZ** 11:00 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner SUNRISE OF PIKESVILLE - 3800 OLD COURT PIKESVILLE BALTIMORE 7. Age (In yrs. lest birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | JAN. 30, 1907 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 M 2 X WISCONSIN Director 218-30-5266 B Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination must be notified as 1 ☐ Yes 2XXNo MD BALTIMORE PIKESVILLE Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3800 OLD COURT ROAD 21208 U.S.A. deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ZMNo tf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. e filed within 72 hours efter al Hygiene. other than "natural", or its 1 ☐ Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 X No Specify: WHITE Specify. g 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) Coilege (1-4or 5+) TEACHER EDUCATION 18 Mother's Name (First Middle Meiden Sumeme) permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy Important: if fem 27 is marked ofth any linjury or other treumatic event Page. 17. Father's Name (First, Middle, Last) ZELONKY LOUIS ANNA PERLMAN 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RABBI MOSHE POMERANTZ / SON 10 OXFORD AVENUE YONKERS, NEW YORK Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 9/18/98 BETH EL MEMORIAL PARK RANDALLSTOWN, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 olice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Due to (or as a consequence ot): disease or condition resulting in death) Examiner Examiner 6 PANCIE CARCINOM A law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury Due to (or as a consequence of): physicial and Box 68760 Physician/Medical that Initiated events resulting in death) Last Due to (or as a consequence of): 88 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.0. eun signed by the 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peen completion of ceuse of death? has The 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Physician: director, 25. Wes cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 → 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Yeer) After this funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending Investigation or Attending 1 Natural 1 ☐ Yes 2 ☐ No deeth. s efter deeth.

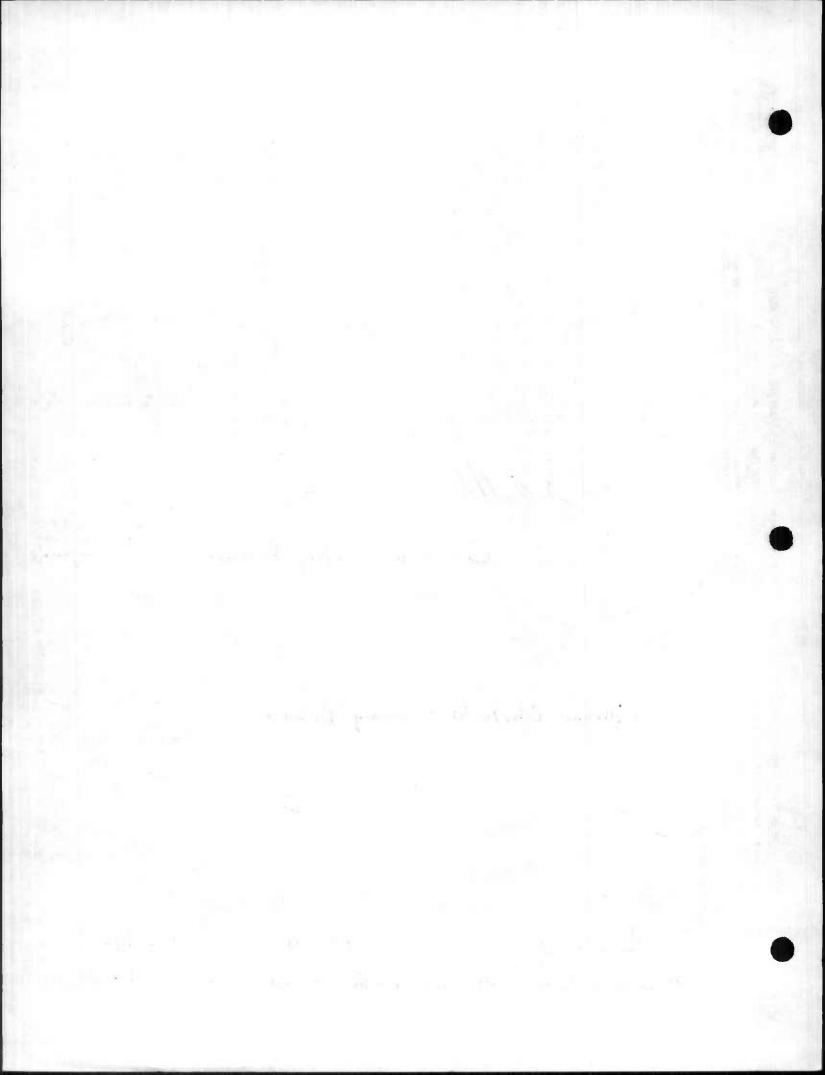
I Director: A
od in by the fo 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours Hospital edical 29a. Certifie 1 Coptifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) and manner es stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only within 2 one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of 9-20482 30. Neme and add person who completed cause of deeth (Item 23e) (Type, Print) 2000 1110 0000 un 6 down how 31. Date filed (Month, Day, Year) 32 Registrar's Signature SEP 2 2 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene

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			Cer	tificate of	Dealli		Reg. No.	0310				
Physician	1. Decedent's Neme (First, Middle, L					2. Date of De Month	ath Day	3. Time of Death				
/Medical	Thomas Frede		ritchar	-			20, 1998					
Examiner	4a Facility Name (If not institution, gi				4b. City, Town, or	Location of Deat	h 4c. County	of Deeth				
	Crofton Convale				Crofton		Anne					
Funeral	5. Social Security Number 6. 544-07-6140	Sex 7. Age (In yrs 1	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	<ol> <li>Birthplace (State or Foreign Country)</li> </ol>				
Director	Usual Residence of Decedent	70	115.			Dec. 25	1919	Oregon				
Du La	10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits				
within 72 hours after death with the Meryland ene. than "natural", or items 23s or 28s-f show he Medical Examine must be notified at simpleted by Funeral Director	MD Anne A	rundel Ode	enton					1 ☐ Yes 2 ☐ No				
the 28s	10e, Street and Number			10f. Zip Code			10g. Citizen of V	What Country?				
23a or	548 Higgins Driv	re .		21113			US					
172 hours after death with the Meryls netural, or items 23s or 28s-f sho idical Examinat must be notified at eted by Funeral Director	11. Meritel Stetus	12. Wes Decedent Ever in	J.S. 13. V	Vas Decedent of I	Hispanic Origin? (S	pecify Yes or No	- 14. Rac	a - American Indien,				
r home strength	1 Never Married 2 Merried	Armed Forces? 1√D Yes 2 □ No			Hispanic Origin? (S an, Mexican, Puerl	o Rican, etc.)	Blac	ck, White, etc.				
"natural", or	3 ☐ Widowed 4 ☐ Divorced	1√□ Yes 2 □ No If Yes, Give Yeer or Dates:		☐ Yes 2½ No	Specify:		Specify	White				
Te la	15. Decedent's E		16a. Deced	ent's Usual Occup	pation		16b. Kind of Bu	usiness/Industry				
ygiene. Ner than "neturi It, the Modell Completed	(Specify only highest gi	rade completed)  College (1-4or 5+)	(Give	kind of work done ONOT use retire	during most of world)	rking						
Hygiene. wher then ent, the te	12	College (1-401 5+)	Majo	r			U.S.	• ARMY				
d other event, b	17. Father's Name (First, Middle, Las	1)			18. Mother's Nar	ne (First, Middle						
ic e	Thomas John Prit	chard			Elizabe	eth Stap	els					
M M M	19a. Informant's Name/Relationship		19b. Mailin	g Address (Street	and Number or Ru			State, Zip Code)				
Heelth ar em 27 la other trau	Bonnie Lou Prito	hard-Wife	548 H	iggins D	rive, Ode	enton, M	D 21113	3				
of Heelth I fem 27 r other tr	20a. Method of Disposition		Place of Dispos	sition (Name of natory or other pla	(0)	Date	20c. Location -	City or Town, State				
	1 ☐ Burial 2 ☐ Cremation 3 € 4 ☐ Donation 5 ☐ Other (Special	_Hemoval from State		Nationa		10/1	Arling	ton VA				
P Indian	21. Signature of Eugeral Service Lice			Name and Addre		10/1	millig	COIT, VA				
Paris Paris	10661	1//2///	H	ardesty :	Funeral H	Home, P.	Α.					
	23a Parti Enter the disease of	rolications that assumed the day	1:	2 Ridgel	y Ave. Ar	napolis	, MD 2	Approximate				
	23a. Pert1. Enter the disease or conshock, or heart failure.	one cause on each line.	in. Do not ente	i the mode of dyn	ing, such as cardian	or respiratory a	11051,	Interval Between Onset and Death				
nysician Medical												
kaminer	disease or condition resulting in death)  a. Oro Nary Arleny NI Jease											
1	Due to (or as a consequence of):											
ial-throsic Examiner												
physician fod s the burial-throsi dical Examir	Sequentially list conditions, if any, leading to immediate	Due to (	or as a consequ	uence ot):								
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):											
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ed by the atte deteched for deteched for Application	Pert II. Other significant conditions	1	A 1		ven in Part I.		Did tobacco use contribute to the cause of d					
detec	Chronic	Obstactie	Pa m	DACE L	i sease	10	Yes 2 No	3 Probably 4 Unknow				
be del				an autopsy	24b. Were autopsy findings							
pege 2 should I							med?	evailable prior to completion of cause				
has pe 2 s								of death?				
pege Com						10	Yes 2 No	1 ☐ Yes 2 ☐ No				
is certificats director, per To Be Co	25. Was case reterred to medical examiner?	Hanabah			OTHER DESIGNATION OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSON OF THE PERSO	ath (Check only	one)					
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After t funer	27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo		28d. Describe	how injury occur	red				
al Director: After led in by the funer.  Certification:	2 Accident investigation			M 1	Yes 2 □ No							
irect n by	3 Suicide 6 Could not to determined			et, tactory, office			ntion (Street and Number or Rural Route Number, or Town, State)					
within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral Medical Certification:		一十十十二年										
within 24 hours after deet To the Funeral Director: completely filled in by the Medical Certifical	(Check only 2 Medical Exa	hysician: To the best of my knominer: On the basis of examination	owledge, death	occurred at the tile	me, date and place	, and due to the	cause(s) and made date and place.	anner as stated. and due to the cause(s)				
Ped Ped	one)	and manner stated.										
To the	29b. Signature and title of certifier			29c. Licens				d (Month, Dey, Year)				
/	Hous 165 ch	4		D 33	7848		9/21	148				
19	30. Name end address of person who	ompleted cause of death (Ite	m 23a) (Type, F	Print)	0 1	. 11	1 0:	F.				
	Howardk Schul	42 Ja 1438 D	etens	e Huy (	Gambr	i11) m	018 0	3 4				
State	31. Date filed (Month, Dey, Year)	32. Registraris Sign	ature	4 1								
Registrar	SEP 2	2 1998 Den	va /	J. pp	acks							



State of Maryland / Department of Health and Mental Hygiene 98 28911

					Cer	tificate of	Death		Reg. No.	y ng	.0911
Physician		me (First, Middle, La						2. Dete of De	eth Dev	Year	3. Time of Deet
/Medical	Will	iam	N	larvin		Pu	rsell	Sutum	our 19, 10	198	6:15 an
Examiner Funeral	4e. Fecility Neme FMK1  5. Sociel Security 214-40-		e Hospit	Age (In yrs. less	HUT binhdey) Yrs.	If Under 1 Year Months Deys	If Under 24 H	or Location of Deel	th 4c. County 10 th 1943	9. Birthple	Ca (State or Fon
	Usuel Residence	of Decedent									
a-f show iffact at	MD.	10b. County Baltin	nore	10c. City, 1 Bal	own or Loc timor					10	od. Inside City Lin 1 ☐ Yes 2 🗗
r Herre 23s or 25s-f s niner, must be notified Funeral Director	10e. Street and No. 7824 Sh	umber eppard Av	e.			10f. Zip Code 2123	4		10g. Citizen of	Whet Counti	ry?
by by	3 Widowed	rried 2 Married 4 ☑ Divorced	12. Wes Deceder Armed Force: 1  Yes 2 fif Yes, Give Yeer or Dates	s? ☑ No		Vas Decedent of H Yes, specify Cub ☐ Yes 280 No		(Specify Yes or No erto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White	
the Medical Completed	(Spe	15. Decedent's E		1	6e. Deced	ent's Usuel Occup	pation	vorkina	16b. Kind of B	. KInd of Business/Industry	
mp idu	Elementery/Sec	condery (0-12)	College (1-4o	r 5+)		kind of work done	d)		Manufa	aturi	200
her the	17 Fether's Name	2 (First, Middle, Last	1		FOL	eman	18 Mother's N	Manufacturing  Neme (First, Middle, Meiden Sumeme)			
and out			Pursell								
marke		Name/Relationship	Type Print)		19b Meilin	n Address (Street	end Number or	Rurel Route Numb	per City or Town	State Zin (	Code
27 is			, ,					ood, MD.			
Department of Heal Important: If Nem 2 any injury or other 9059.	Mr. Ronald Pursell/ Brother  20e. Method of Disposition  12 Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, cremetory or other place) Parkwood Cemetery  9-22-9								20c. Location - City or Town, Stete		
		uneral Service Lice			22.		wson Fu	neral Hor			
ing physician and eas the burial mansit	Sequentially list of if eny, leading to it cause. Enter Und Cause (Disease of their initieted even resulting in deeth)	onditions, mmediate lerlying r injury ts Lest	. Tobacc	Due to (or es	Se consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequenc		.0n			1	le day 10 year
been signed by the ettendin should be detached for use leted by Physician/N	Pert II. Other sign	ificant conditions of	d	but not resultin	ng in the un	derlying ceuse giv	ven in Pert I.		tobacco use co Yes 2□ No		the causa of dea
page 2 should be de Completed by I									en eutopsy ormed?	evel	re eutopsy finding lleble prior to apletion of ceuse eeth?
director, page 2								10	Yes 20 No		Yes 2 No
ertifical ector, p	25. Wes cese refe	rred to medicel	,				26. Plece of D	Deeth (Check only			
00	exeminer?	Zhio	Hospital:	tient 2□ER	/Outpetient	3□ DOA Oti	hor	Home 5□Res		ner (Specify)	)
within 2x hours are to be unit to the funeral Director. After this completely filled in by the funeral Medical Certification: 1	27. Menner of Dee 1 Maturel 2 Accident	th 5 ☐ Pending investigatio 6 ☐ Could not b									
al Direct led in by	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Plece of I building,	njury - At home etc. <i>(Specify)</i>	, ferm, stre	et, fectory, office		28f. Location ( City or To	(Street end Numi wn, Stete)	per or Rural	Houte Number,
To the Funeral completely filled	29a. Certifier (Check only one)	1 Certifying Ph 2 ☐ Madical Exam	nyelclan: To the bes ninar: On the basis and manner:	of examinetion	dge, death end/or inv	occurred et the ti estigetion, in my o	me, dete end ple opinion, deeth oo	ece, and due to the courred et the time,	ceuse(s) end modate and plece,	enner es ste and due to t	eted. the ceuse(s)
Tota	29b. Signeture en	Swith	2. Cham	UL I	o. O.	29c. Licens	88854		29d. Dete signe	DUY	19, 199
X	30. Neme end edd	lress of person who	completed cause of	death (Item 23	Ra) (Type F	l eintl					

State of Maryland / Department of Health and Mental Hygiene

Physic	ian	1. Decedant's Name (First, Middle Lawrence		Ca				2. Dete of Dea Month	Dey	Year	ime of Deet			
/Medi	cal			- 11			th City Tours or	Septemb Location of Deeth	1	1 - 2 7	259			
Exami	ner	4a. Facility Name (If not institution	1		2.0				,	. 1				
		5. Sociel Security Number	KINS Bay	ne (In vis le	ast birthdey)	If Under 1 Yes		1+1More		N/A	tab or For			
uneral irector		214-50-4776 Usuel Residence of Decedent	1 <b>⊠</b> M 2□F	50	Yrs.	Months Day				9. Birthplace (S Country) Baltimor				
ž ti		10e. Stete 10b. County		10c. City	, Town or Loc	ation				10d. Ins	ide City Lir			
r 28a-f show	ctor	MD Balti	more	Peri	ry Hall	L				1	Yes 2			
23a or 28	Funeral Director	10e. Street and Number 9617 Dundawan I	Road			10f. Zip Code 2123			10g. Citizen of V USA	Vhat Country?				
st, or items Examiner in	by	11. Merital Stetus  1 Never Married 2 Marr  3 Widowed 4 Divorced	If Yas Give	? I No		vas Decedent o Yes, specify Ci □ Yes 2 R	f Hispanic Origin? ( uben, Mexican, Pue lo <i>Specify:</i>	Specify Yes or No- rto Rican, etc.)	14. Rece - American Indian, Bieck, White, etc. Specify: White		an,			
an "naturel",	To Be Completed	15. Deceden (Specify only higher Elemantary/Secondary (0-12)	t's Education at grade completed) College (1-4or	5+)	_		cupetion ne during most of wo ired)	orking	16b. Kind of Business/Industry  Carpentry					
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s marked other than " numatic event, tre Mer	o Be	17. Father's Name (First, Middle, Joseph Peter P						me (First, Middle, ose Mallo		Θ)				
is mar	r traum	19e. Informent's Neme/Relations	hip (Type, Print) sis	ter	19b. Melling	Address (Stre	et end Number or F	Rural Route Numbe	or, City or Town,	Stete, Zip Code)				
27 r tr		Louise Posluszn	у		9617 Dundawan Rd.					d 21236				
		20a. Method of Disposition  1 □ Burlai 2 ☑ Cremetion  4 □ Donation 5 □ Other (S)		9		ition (Name of etory or other p t Cemet		Dete 9/21/98	/21/98 Baltimore, Maryland					
Important: If is any injury or		21. Signature of Funerel Service Licensee  22. Name end Address of Facility Joseph N. Zannino J  263 S. Conkling St., Baltimore, Md.												
edical edical iminer	miner	Immediete Ceuse (Final disease or condition rasulting In deeth)	a. M b. A1	cohol	ism		Arction			da. yen	( <u>s</u> Hes			
attending physician and for usa as the burial-transit	n/Medical Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseesa or Injury thet initiated events resulting in deeth) Lest	c		es e consequi									
e atte	sicia	Part II. Other significant condition	ns contributing to death	but not resul	iting in the und	deriving cause	given in Pert I.	23b. Did 1	obacco use cor	tribute to the ca	use of de			
signed by the atten I be detached for u	y Phys								Yes 2□ No	3 Probably	4 Unk			
hould	Completed by Physician/N							24a. Was perio	an eutopsy med?	24b. Were auto availabla completio of deeth?	prior to			
paga paga	Con							101	res 2 No	1 🗆 Yes	200 No			
is cartificata has t director, paga 2 s	To Be	25. Was case referred to medical exeminer? 1 ☐ Yes 2 No	Hospitel:	nostlent 2 TER/Outs		3□ DOA (	When	eath (Check only o		er (Specify)				
or: Aftar this ha funaral di	ation:	27. Manner of Deeth  1 Neturel 5 Pendin 2 Accident Investig	ation	ury By Year)	28b. Time of Injury	28c. In W M 1		28d. Describe how Injury occurred						
To the Funeral Director: Aftar thi completely filled in by the funeral	Medical Certification:	3 Suicide 6 Could not be determined 28e. Piece of injury - At home, farm, street, fectory, office building, etc. (Specify)							m, Stete)	er or Rurai Route	Number,			
Funel ataly fil	dicai	29e. Certifier (Check only one) 1 Certifyin 2 Medical	g Physician: To the best Examiner: On the basis of end menner s	of examination	rladga, death on and/or inve	occurred et the estigetion, in my	time, dete end pled y opinion, deeth occ	e, end due to the curred et the time,	cause(s) and me data end placa, (	nner as stated. and due to the ca	use(s)			
	Me	29b. Signeture and title of certifier	0				nse number			d (Month, Day, Y				
To the		. /1	2 /				000		6 .1.	10	100			
Tothe		30. Nema end address of parson	do Trost	- M.	D.	(I-N	98023 Lopkins 1		Jepte	MBCR 18	177			

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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death mor if Under 24 Hrs. 5. Social Security Number If Under 1 Year 6. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days -32-1 M 20 F Months Hours Min. Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland 1 Yes 2 □ No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 0 12. Was Decedent Ever in Ü,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 Never Merried 2 Married 1☐ Yes 2⊠No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a, Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of gemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service bicenser 22. Neme end Address of Facility KU orth 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Ceuse (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or es a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 42 Unknown 1 Yes 2 No 24b. Were autopsy findings aveilable prior to 24a. Was en eutopsy performed? completion of cause of death? 2 0 No 1 Yes 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work?

**Physician** /Medical Examiner

Department of Important: If any Injury or once.

**Physician** /Medical

Examiner

10a. State

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland inner of health and Mental Hygiene.
WILL If them 27 is marked other than "natural", or items 23a or 23a-f show any or other traumatic event, it is findical Examinar man be notified at my or other traumatic event, it is findical Examinar.

Baltimore, Maryland 21215-0020

Physician/Medibal Examiner Completed by To Be

Box 587

Division of Vital Records, P.O.

1 After or Attending n 24 hours after death. As Funeral Director. A platsity filled in by the To the To the To the R

State Registrar

Certification:

Medical

1 Naturel

3 Suicide

4 Homicide

(Check only one)

25b. Signature and title of certi

31. Dete filed (Month, Day, Year)

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) 19MPI

SEP

5 Pending Investigation

6 Could not be

2 2 1998

au 32. Registrer's Signeture

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

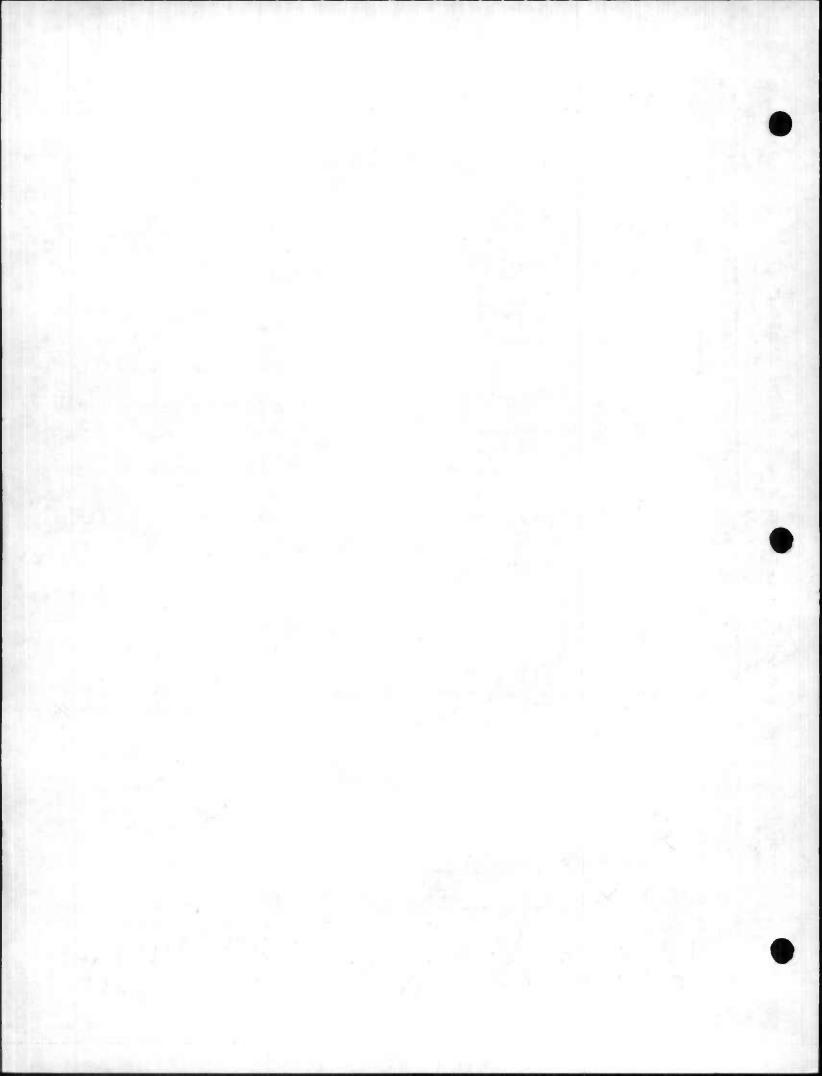
Recrtifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

The Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** September 20,1998 9:00 RIEGEL ALBERT /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street end number) 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Yeer) **Funeral** Min. 1 M 2 F Months Days Hours 79 Yrs. 108-07-9477 New York Director Nov. 7, 1918 Usuel Residence of Deceden with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahov traumatic event, the Medical Experience, must be notified at Maryland Baltimore 1 ☐ Yes 2 🕱 No Baltimore Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filled within 72 hours after death with Department of Haelfh and Mental Hygiene.
Important: If them 27 is marked other than \*\*--any injury or other traument—
any injury or other traument— 29 Stone Falls Ct. 21236 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1½ Yes 2 □ No if Yes, Give Year or Dates: WW 7.7 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Manager Service Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Philip Ada Riegel Kenning 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Eileen Barbara Riegel (wife) 29 Stone Falls Ct., Baltimore, MD 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burlel 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. Cem 9/23/98 Owings Mills, MD 22. Name and Address of Facility
Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licensee Brian a. Willen 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) a LIVER CANCER Examiner Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of ceuse of death? hes this cartificata 1 Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE <sup>2</sup> 1 Yes 2 XNo funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Aftart Certification: or Attending Partar daath. 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 - Homicide To the Hospital o within 24 hours af To the Funeral Di

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

EDDIE NAKHUDA, 2300 DULANEY VALLEY RD., TIMONIUM, MD 21093 31. Date filed (Month, Day, Year)

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated.

29c. License number

1550

29d. Date signed (Month, Dey, Year)

ey 20. 98

State Registrar

complately

29a. Certifier

(Check only one)

29b. Signature and title of certifier

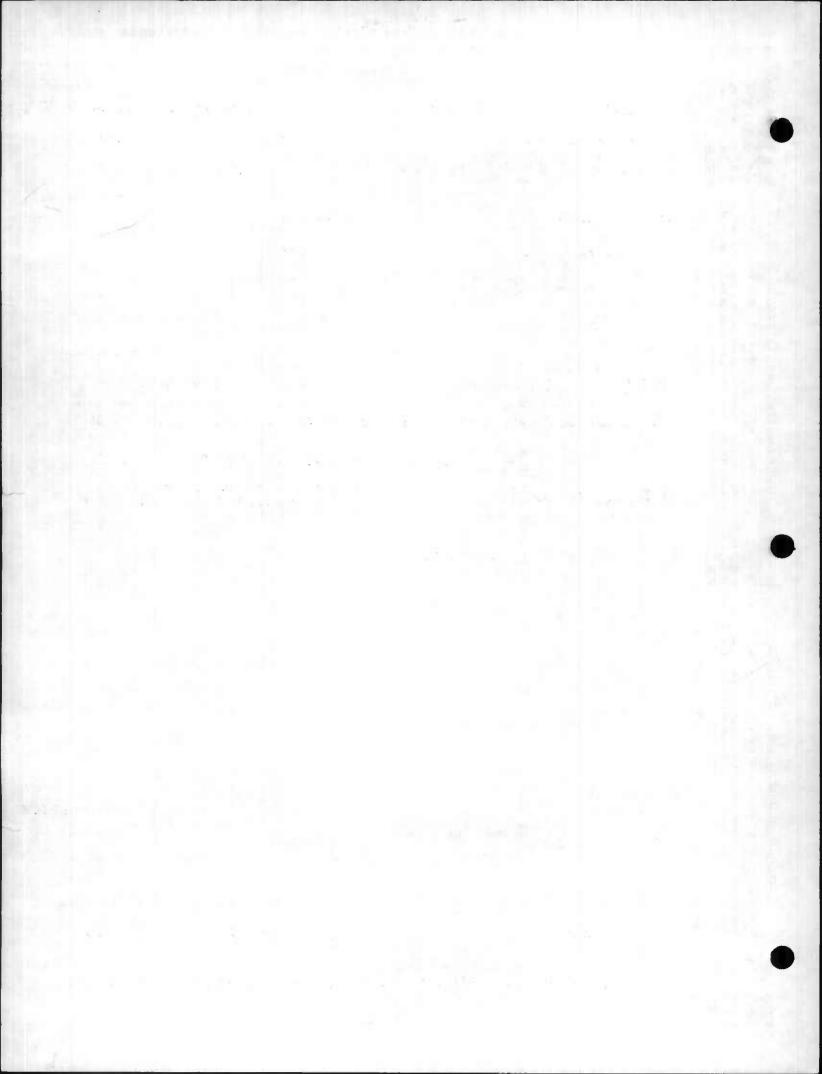
SEP 2 2 1998

Sthods

Medical

32. Registrar's Signature

ms



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #19a Per FH Film G763 9-22-98RC Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** NIKHEMA REVZIN 9 Sept.
4b. City, Town, or Location of Deeth 11: 30 AM /Medicai 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner BALTIMORE LITURIORE MIN. 8. Dete of Birth (Month, Dey, Year) MANOR NURSINB
6. Sex 7. Age (In yrs. lest birthday) 14 014 E BALTIMONE 5. Sociel Security Number Birthplace (State or Foreign Country) Funeral 1□ M 2 F Deys 218-96-1181 Months Yrs. Director UKRAINE Usuel Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23e or 28a-f show the Medical Examiner must be notified at 1 ☐ Yas 2 No Director BALTIYONE 14 AAYLAND BALTIMONE 10f. Zip Code 10g. Citizen of Whet Country? UKRAINE ROAD 21208 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ■ No Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritei Stetus 14. Race - American Indien, Bieck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 2 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Coilege (1-4or 5+) EDVCATION BOOKKEEPER 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middia, Malden Sumeme) Be Health and Mentel is marked ARON REVZINA PAULHER Meiling Addrass (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 4603 mportant: If Item 27 BALTO. MA 21208 20e. Method of Disposition

1 ■ Burial 2 □ Cremetion 3 □ Removel from State 20b. Pieca of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete to SEPT 2-1998 4 ☐ Donetion 5 ☐ Other (Specify) BALTIMONE HEBREW REISTERSTOWN 140 22. Name end Address of Fecility Set LEVINSON 21. Signeture of Fune at Service Licensus +BNOS, INC 8900 REISTERSTOWN RD BALTO 140 21208 rune disease or complications that caused the death. Do not enter the mode of dyling, such as cardiac or respiretory errest, fart failure. List only one cause on each line. Approximata Intervei Between Onset end Deeth **Physician** /Medical Myocardia immediate Ceuse (Finel 1 hour diseese or condition rasulting in deeth) Examiner Physician/Medical Examiner Sequentielly list conditions, if eny, laeding to immediate causa. Entar Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest Due to (or as e consequenca of): Box 68760, Due to (or es e consequence of) the P.O. Pert II. Other eignificent conditione contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detact 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No Records, by 24b. Were autopsy findings eveilable prior to Be Completed 24e. Wes an eutopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Wes case rafarred to medical examiner? 26. Plece of Deeth (Check only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Director: After this in by the funerel 27. Menner of Daath 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred After 5 Panding investigation 1 Naturel death. 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicida Hospital 1 Certifying Physician: To the best of my knowledga, deeth occurred at the time, date end piece, end due to tha causa(s) and mannar as steted.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date end piaca, end due to the ceuse(s) end menner steted. Medical 29a. Certifier the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 051426 30. Neme end eddress of person who complated cause of deeth (Item 23e) (Type, Print) Rothschild 4000 020 COUNT NO SUITE 301 BALTO 140 21208

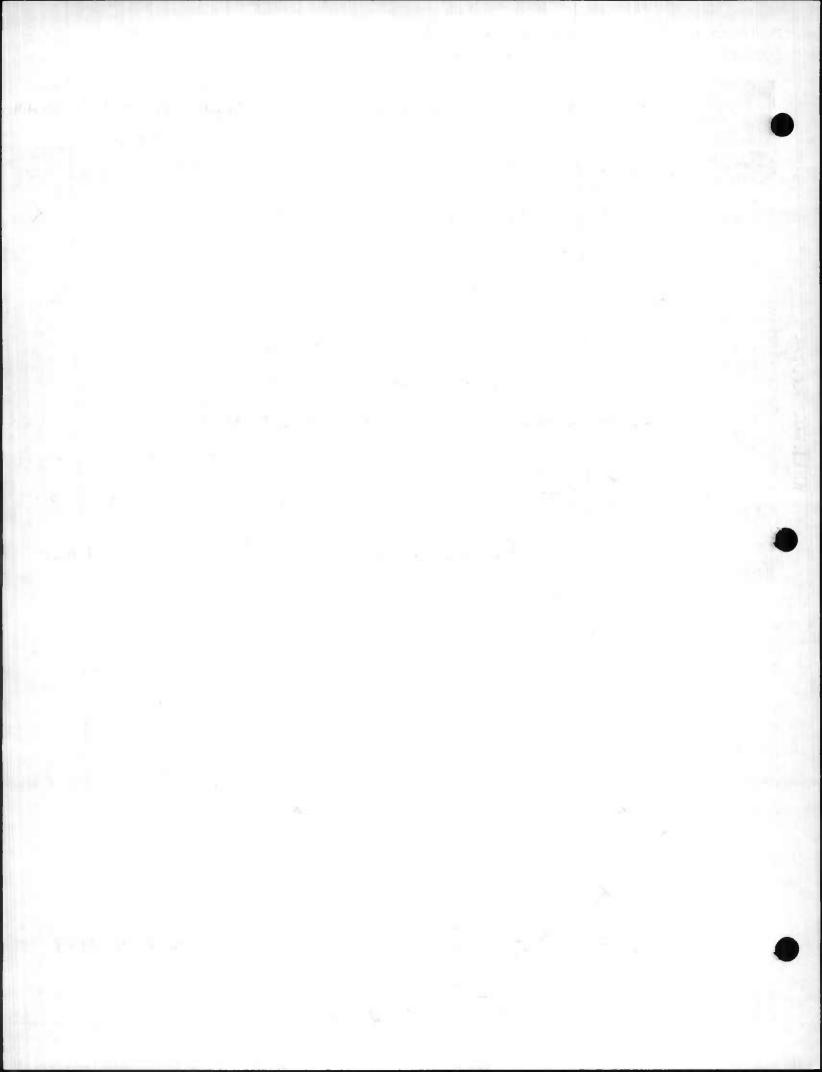
State Registrar

Elliot S.

31. Dete filed (Month, Day, Year)



MD



State of Maryland / Department of Health and Mental Hygiene 9 8 Amend: #10e Per FH Film G763 9-22-98RC Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dete of Deeth 3. Time of Deeth Day **Physician** SEPT. 18, 1998 ROSENBERG 2:50 PM /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (if not institution, giva street and number) 4c. County of Death Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Under 24 Hrs. 8. Data of Birth 9. Hours Min. (NOV Day 30, 1904 9. Birthplaca (Stata or Foreign
4 County MARYLAND 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** 1 M 2 DXX Months Days 216-32-7809 93 Yrs. **Director** Usual Rasidenca of Decedant the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show BALTIMORE MD PIKESVILLE 1 Yas 2 N Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ed other than "natural", or items 23s or event, the Medical Examiner must be 700 KAIN DRIVE 207-A OAK AVE. 21208 USA permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the We Funeral 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 【XYO If Yas, Give Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lt Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black Whita, etc. 1 □ Navar Marriad 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 X No Specify: WHITE Specify þ 3 X Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Collega (1-4or 5+) Elementery/Secondary (0-12) BOOKKEEPER CLOTHING MANUFACTUR 12 18. Mothar's Nama (First, Middla, Meiden Sumama) 17. Fether's Nama (First, Middla, Last) Be **JACOB** FRANK BESSIE SPEERT 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Typa, Print) 15 PINEWOOD FARM CT; OWINGS MILLS, MD 21117 DR. HERBERT ROSENBERG / SON 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20c. Location - City or Town, Stete 20e. Mathod of Disposition 1 ☐ Surial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 9/20/98 BNAI ISRAEL BALTIMORE, MD 21. Signatura of Funeral Service Licensee 22. Name end Addrass of Facility SOL LEVINSON & BROS, INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest,

Approximate the mode of dying, such as cardiec or respiratory errest,

Approximate the mode of dying, such as cardiec or respiratory errest, Approximate Interval Batween Onsat and Death **Physician** Immadiata Causa (Final disaasa or condition rasulting In deeth) /Medical pneumonia) Examine Physician/Medical Examiner tered mental status The law requires that the death certificate be executed Sequantially list conditions, if eny, laading to immediate causa. Entar Underlying Causa (Disease or Injury that initiated avants rasulting in daeth) Last physician and Division of Vital Records, P.O. Box 68760. Dementia Due to (or es e consequence of): 080 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Protein energy malnutration signed t 2 24b. Wera autopsy tindings available prior to complation of causa of daath? been si should 24e. Wes en eutopsy performed? Completed certificata has b 2 No 1 ☐ Yes 1 □ Vas 2 □ No Physician: director, Be 25. Was casa referred to medical axaminar? 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Residence 8 Othar (Specify) 1 Yas 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 2 this funeral 27. Menner of Daath 1 Netural 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? Certification: After or Attending 5 Panding 1 Yas 2 No investigation after death. Director: A 2 Accidant 6 ☐ Could not be determined 3 ☐ Suicida 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, ferm, street, factory, offica building, atc. (Specify) the Funeral Director filled in by 4 Homicida 🔀 Certifying Phyalcian: To tha bast of my knowladga, deeth occurrad at tha tima, data and plece, and dua to tha causa(s) and mennar as stated. edical 29a. Cartifian 2 Medical Examiner: On the besis of examinetion end/or invastigation, in my opinion, death occurred at tha time, data end place, and due to the cause(s) and manner stated. (Check only one) within 2 To the Complet 29d. Date signed (Month, Dey, Year) 29b. Signeture end titla of certifiar 29c. Licansa number September 18, 1998 D28462 (Soston) 10 30. Neme end address of person who completed cause of daath (Itam 23e) (Typa, Print) Hospital Center 5401 OH Court Road Northwest 32. Registrar's Signatura State Registrar

BALTIMORE

MD 2 /201

EUTAW ST.

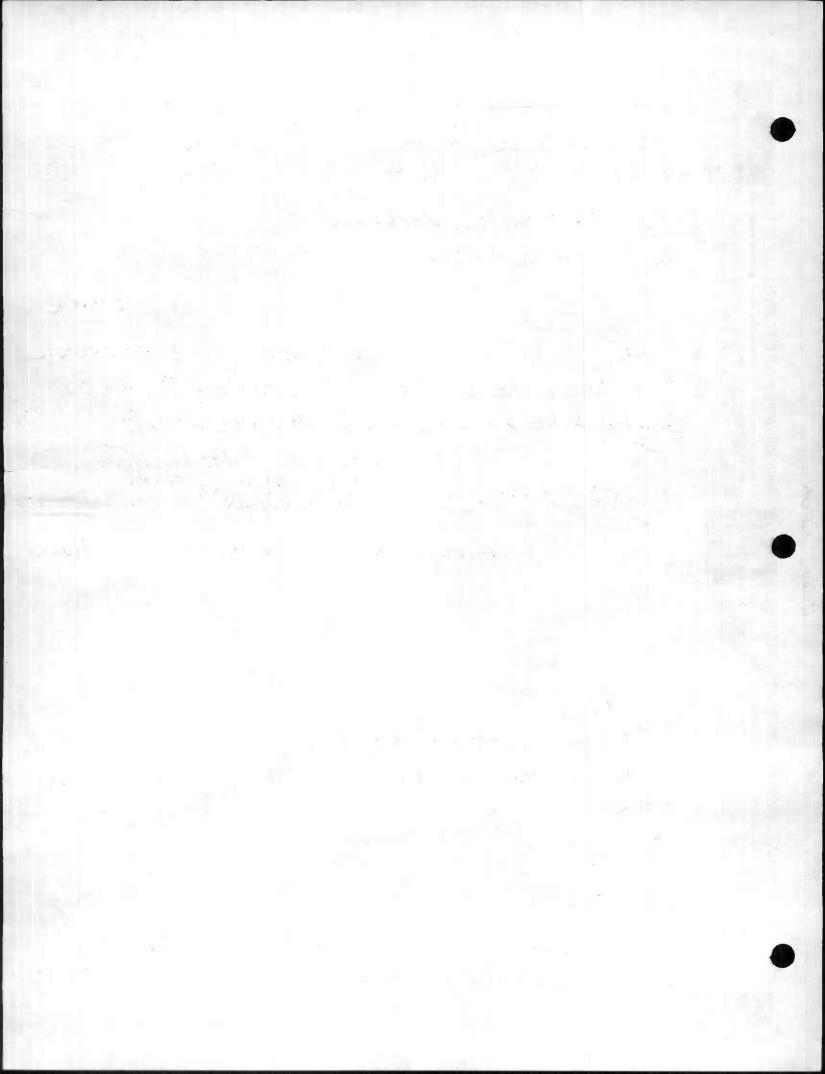
Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURJIT S JULKA M. D. 82/ N.

32. Registrar's Signature

31. Dete filed (Month, Day, Year)



### Piease Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 07:11 pm 4b. City, Town, or Location of Death 1998 Joseph C. Selway 0 4c. County of Deeth 4e Fecility Neme (If not institution, give streat and number) Saint Agnes Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Yeer) 01/19/1912 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Sex 1M 2□ F Months Deys Hours Min Yrs 86 215-07-6139 Maryland Usual Residence of Decedent 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Woodlawn Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21207 1807 Alto Vista Road USA 13. Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, atc.) 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ Yoo If Yes, Give Year or Dates: 14. Race - American Indien. Bleck, White, etc. 1 Never Married 2 Married 1 Yas 2 No Specify: Specify: White 3 Widowad 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15, Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Carpenter Cabinet Making 12th 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Kraeski James W. Selway Mary 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Ruret Route Number, City or Town, Stete, Zip Code) Baltimore, Maryland 21207 Dorothy S. Selway / Wife 1807 Alto Vista Road 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 9/24/98 Baltimore, Maryland Woodlawn Cemetery 4 Donetlon 5 Other (Specify) 21. Signalere of Funeral Service Liouvis 22. Name end Address of Fecility David J. Weber Funeral 5311 Edmondson Ave. Baltimore, Maryland 21229 23e. Pert1. Enter the disease of complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. It is conly one ceuse on each line. Approximete Intervel Between Onset and Death Immediata Causa (Final disease or condition resulting in deeth) Sepsis 5 days Due to (or es e consequence of): Circhosis IVEF YLONS Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es a consequence of) ulmonary FIGNOSIG YLOYS Dua to (or as e consequence of): Esophageal voricul Bleeding 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 1 □ Yes 2 □ No 3 □ Probebly Unknown 24b. Wera eutopsy findings evelleble prior to 24e. Wes en eutopsy completion of cause of deeth? 1 ☐ Yes 2 No 25. Wes cese referred to medicel axaminar? 26. Place of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 □Other (Specify) 1 Inpatient 2 ER/Outpetlent 3 DOA 27. Menner of Deeth 1 Aletural 2 ☐ Accident 28d. Describe how Injury occurred 28c. Injury et Work? 28b. Time of 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Sulcide 28e. Plece of Injury · At home, farm, street, fectory, office building, etc. (Specify) 281. Location (Street end Number or Rurel Routa Number, City or Town, Stefe) 4 | Homicide Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner as stated. [2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted. 29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

21224

September 20, 1998

Joseph Selway

**Physician** 

/Medical

**Examiner** 

Director

Funerai

à

Completed

**Funeral** 

Director

item 27 is marked other than "naturel", or items 23s or 28s-f show other traumstic event, the Medical Examinar must be notified at

injury or

**Physician** /Medical

Examiner

98

USB 0

certificate hes

After this

deeth. after deeth Director:

24 hours

To the Vithin 2

Examiner

Physician/Medical

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Completed

Be

2

Certification:

Medical

parmit. Peges 1 end 2 should be filed within 72 hours efter death Department of Health end Mental Hygiene.

Baltimore, Maryland 21215-0020

the Merylend

Registrar

31. Dete filed (Month, Dey, Yeer)

Caton

29b. Signeture end title of certifier

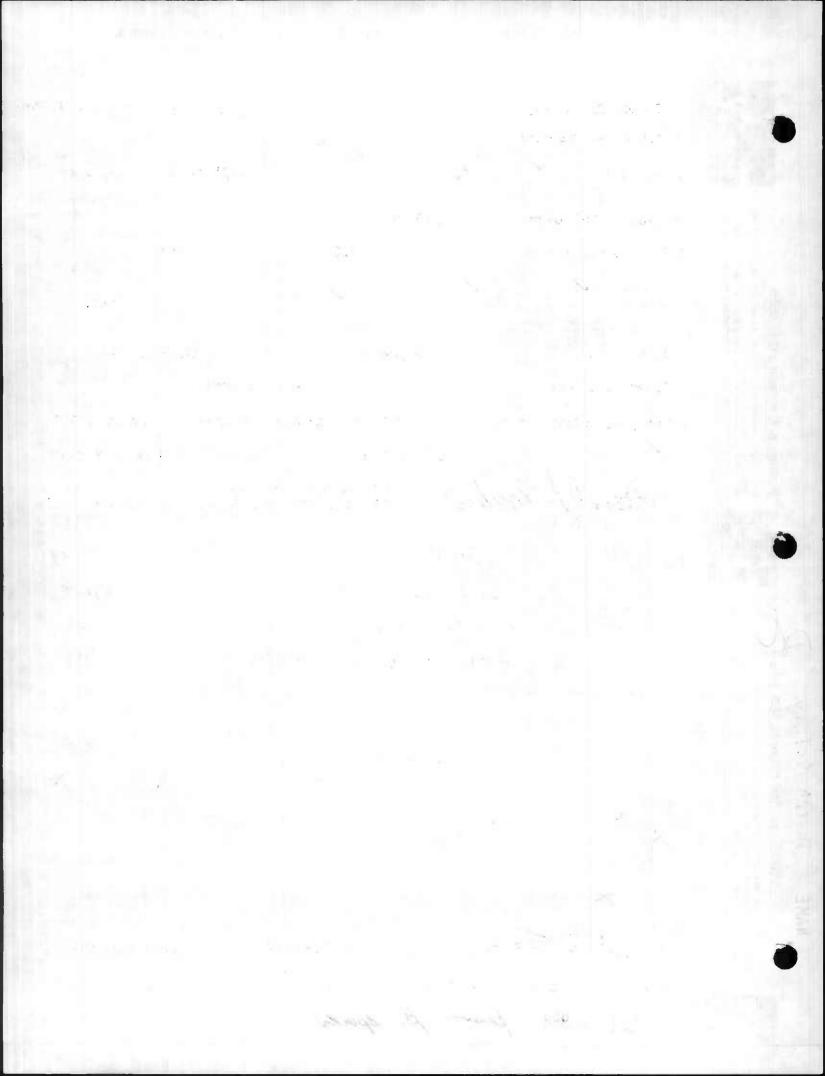
(Check only one)

ICNIC

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

Baltimore City, Maryland 32. Registrar's Signature

**DHMH 16 Rev 6/95** 



## Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland	Department	of Health	and Mental	Hygiene
	Certificate	of Death		D M

CZPANSKI		State	n Marylan			of Death	a Mental Hy	Reg. No.	8 28	919			
Physician	Norbert	NOLDELC A. SZCZEDANSKI								Time of Deeth 8:12 PM			
/Medica Examine	An Plantithe Stance Hill mad Incational	n, give street end nu					Month SEPTE or Location of Dee						
Funeral Director	5. Sociel Security Number 2/8-48-2057	6. Sex 11⊈ M 2□ F	7. Age (In yrs. 52		If Under 1 \ Months D		lin. (Month, D	rth ey, Yeer) 5/1946	9. Birthplece Country) Maryla	(Stete or Foreign			
yland	Usuel Residence of Decedent  10e. Stete 10b. County		10c. Cit	y, Town or Lo	cation				10d. le	nside City Limits			
	MD		Ba	altimo	re			3	€ Yes 2 No				
ith the M or 28a-f	10e. Street and Number	_	10f. Zip Code					10g. Citizen of					
eth w	139 S. Linwo					224		USA		41			
9 2 6	3 ☐ Widowed 4 ☐ Divorced	ried 1 ☐ Yes	2⊠No ve		Was Decedent f Yes, specify I ☐ Yes 2X	t of Hispenic Origin? Cuban, Mexicen, Pu No Specify:	(Specify Yes or Nuerto Ricen, etc.)	Specify	ce - American Inck, White, etc.  y: Whit				
within 72 hours one. then "netural",	15. Deceder (Specify only higher Elementery/Secondery (0-12)	nt's Education st grade completed)		16e. Deced (Give life.	lent's Usuel C kind of work of OO NOT use r	ccupetion lone during most of etired)	working	16b. Kind of B	usiness/Industr	1			
212 od within glene. er then	12	College (	1-401 34)	Prin	ter M	anageme		Print					
Maryland A 2 should be fit the and Mental H 27 Is marked out t traumatic even To Be	17. Father's Neme (First, Middle,					18. Mother's i	Name (First, Middle	a, Melden Sumer	ne)				
			. Sz	czepa		Ceci			iecial				
	19e. Informent's Na <i>me</i> /Reletionship (Type, Print)  19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)  Philip Szcsepanski/Brother 2645 Chesterfield Ave. Balto. MD 21213												
Baltimore, Memit. Peges 1 and 3 bendment of Health moortant: if Item 27 1 and 10 in y Injury or other trunce.	20a. Method of Disposition  1 Mag Buriel 2 Cremetion  4 Donetion 5 Other (5	3 □Removal from	20b. F	Place of Dispo	sition (Neme	of	Date	20c. Location	- City or Town,	Stete			
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Carlotte be so	resulting in deeth) Lest	d	Due to (or es e consequence of):										
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Vital Filterian: The certificate rector, pag							Deeth (Check only	one)					
Of Vita Physician: this certific ral director.	1 X Yes 2 No		Inpatient 2				g Home 5 K Res						
ding P	27. Manner of Deeth  1 Naturel  5 Pendi	. A	of Injury oth, Day Year)	28b. Time of Injury	28c.	Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occur	rred				
Division C tal or Attanding P is effar death. al Director: Affer ti led in by the funera	2 Accident Invest 3 Suicide 6 Could 4 Homicide determ	nined   286, Pieci	e of Injury - At hi ing, etc. (Specif	ome, ferm, str				(Street and Num own, Stete)	ber or Rurel Ro	ıte Number,			
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8	30. Neme and eddress of person JOSEPH PESTAN		se of deeth (Iter			reet, Balt	imore, M	aryland	21201				

State Registrar

31. Date filed (Month, Day, Yeer) SEP 2 2 1998

32/Registrer's Signature

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** 9115AM August liam 1998 16, 1998 4c. County of Deeth /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner | FUndar 28 Hrs. 8. Data of Birth | Min. | Month, Day, 5. Social acurity Number 4000 River C ove, recent 6. Sex. 9. Birthplace (Stata or Foreign Country) PENNSY VAN JA 7. Aga (In yrs. last birthday) **Funeral** Months Days 86 Yrs. 601 Director Usual Rasidance of Decedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hypiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic avent, the Madical Environment by notify day once. 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director Anne Arunde Jary hoo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 USA 6202 rescent Funeral 12. Was Dacedant Evar in U.S. Armed Forcas? 1 XYas 2 No IYYes, Giva Yaar or Datas: W Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Mexicen, Puarto Rican, atc.) 14. Race - Amaricen Indian 11. Marital Status Black, Whita, atc. 1 Nevar Married 2 Married 1 Yas 2 No Baitimore, Maryland 21215-0020 Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elemantary/Secondery (0-12) Collega (1-4or 5+) Th resident Danking 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) -awrence Martia Hickman 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 2 40 19a. Informant's Name/Reletionship (Type, Print) 6202 River Crescent Drive, Annapolis MC S. Smith TimerCove 20b Plece of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata WestChesterKennsylvia 4 □ Donation 5 □ Othar (Specify) 18 98 erris remotor 21. Signature of Funaral Sarvice Licensee Home street, Baltimore, MD 2123 David J. Weber, Per DVR Sichester 401 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Interval Batween **Physician** Immediata Causa (Final disease or condition rasulting in death) /Medical COPI Examiner Due to (or as a consequance of) Examiner mortanic The lew requires that the death certificate be axecuted Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Dua to (or as a consequence of): physicien the burial Box 68760. Physician/Medical Dua to (or as a consequence of): 980 Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2□ No 3 Probably 4 Unknown malignance Completed by 24a. Wes an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? Grosan 1 ☐ Yes 1 ☐ Yas 2 ☐ No or Attanding Physician: 25. Was casa refarred to medical exeminer? Certification: To Be 26. Place of Death (Check only ona) Hospital: Other: Nursing Homa 5 Rasidence 6 Othar (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Dey Year) 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Panding invastigation after death. 1 Yes 2 No 6 Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28a. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) filled in by 4 Homicida 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data end place, and due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Cartifiar Medical completely (Check only one) To the To the To the 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 38158

State

Registrar

DHMH 16 Rev 6/95

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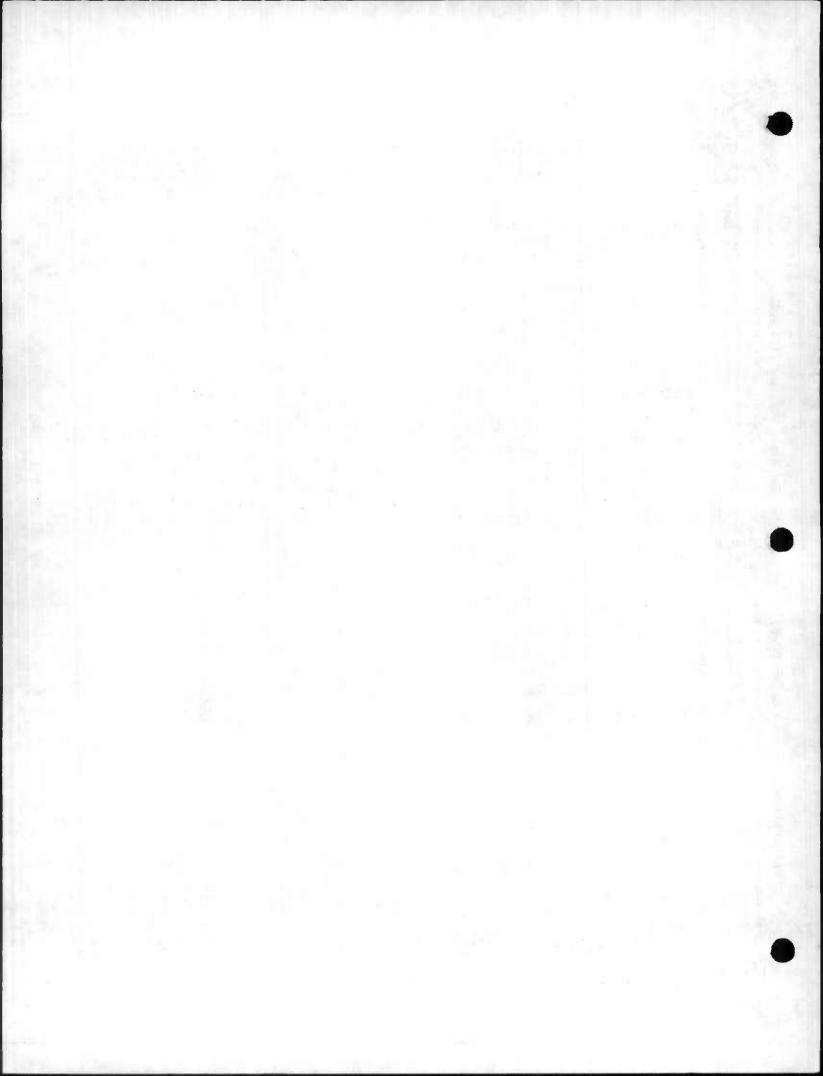
32. Ragistrafr's Signatura

Pkey 7100 Amapdis MC

21032

30. Nama and addrass of person who complated ceusa of daath (Item 23a) (Type, Print)

DiMar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend: #9 Per FH Film G763 9-22-98RC 1. Decedent's Nema (First, Middla, Last) 2. Dete of Deeth 3 Time of Deeth **Physician** MARJORIE SANTIAGO SEPTEMBER 17,1998 /Medical 4a. Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Church Hospital Baltimore 5. Social Security Number If Undar 1 Year | if Under 24 Hrs. 8. Date of Birth 02/10/1930 7. Aga (In yrs. last birthday) 10M 20F Hours 68 Yrs. 234-70-7919 Usual Residence of Decedent 10e Steta 10h County 10c. City, Town or Location 10d. Inside City Limits 1 NYes 2□No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2702 Orleans Street 21224 USA Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Giva Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Rece - Amarican indian, Black, White, etc. 11. Maritai Status 1 Never Merried 2 Married 1□ Yes 21 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 6th 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middla, Meiden Sumema) Hayman S. Kerr Lucille Grin 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) Vivian Forbes / Daughter 216 N. Belnord Avenue Baltimore, Maryland 21224 20b. Plece of Disposition (Name of cometery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cramation 3 Removal from Stete 9/21/98 Webster Co., WV 4 ☐ Donetion 5 ☐ Other (Specify) Miller Cemetery 21. Signature of Funerel Service Licanse 22. Neme and Addrass of Facility David J. Weber Funeral Home 401 S. Chester Street Baltimore, Maryland 21231 23e. Pert1. Entar the disease, or obsolications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate intervel Between Onset and Deeth Immediate Causa (Final LUNG CANCER WITH METASTASIS month disease or condition resulting in death) Physician/Medical Examiner Sequentielly list conditions, if eny, leeding to Immadieta cause. Enter Underlying Ceuse (Disease or Injury that Initiated avents resulting in deeth) Last Due to (or as e consequence of): Due to (or es a consequance of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No CONGESTIVE HEART FAILURE þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? Completed CHRONIC OBSTRUCTIVE PULMONARY DISEASE DIABETES MELLITUS 1 Yas 20 No 1 Yas 2 Tho 25. Wes case referred to medicel Be 28. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 27. Menner of Death 28b. Time of 28c. Injury et Work?

and P.0. signed b Records, certificate Division of Vital To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

**Physician** /Medical

Examiner

**Funeral** 

Director

28a-f show

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Herns 23a

permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hyglene. Important: If frem 27 is marked other than "natural", or then any injury or other treumatic avant

Baltimore, Maryland 21215-0020

treumstic event, the Medical Examiner must be notified at

Certification: To

Medical

5 Panding investigation 6 Could not be determined

28a. Dete of Injury (Month, Dey Year)

28e. Plece of Injury - At homa, farm, street, fectory, office building, etc. (Specify)

28d. Describe how injury occurred

BALTIMORE, MARYLAND 21231

28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred et the time, dete end piece, and due to the ceuse(s) end manner steted.

29b. Signatura and title of certifier Jexavarronu

1 Neturel

2 Accident

3 Suicide

29e. Certifier

4 D Homicida

and - Specialist

29c. License number

1 Yes 2 No

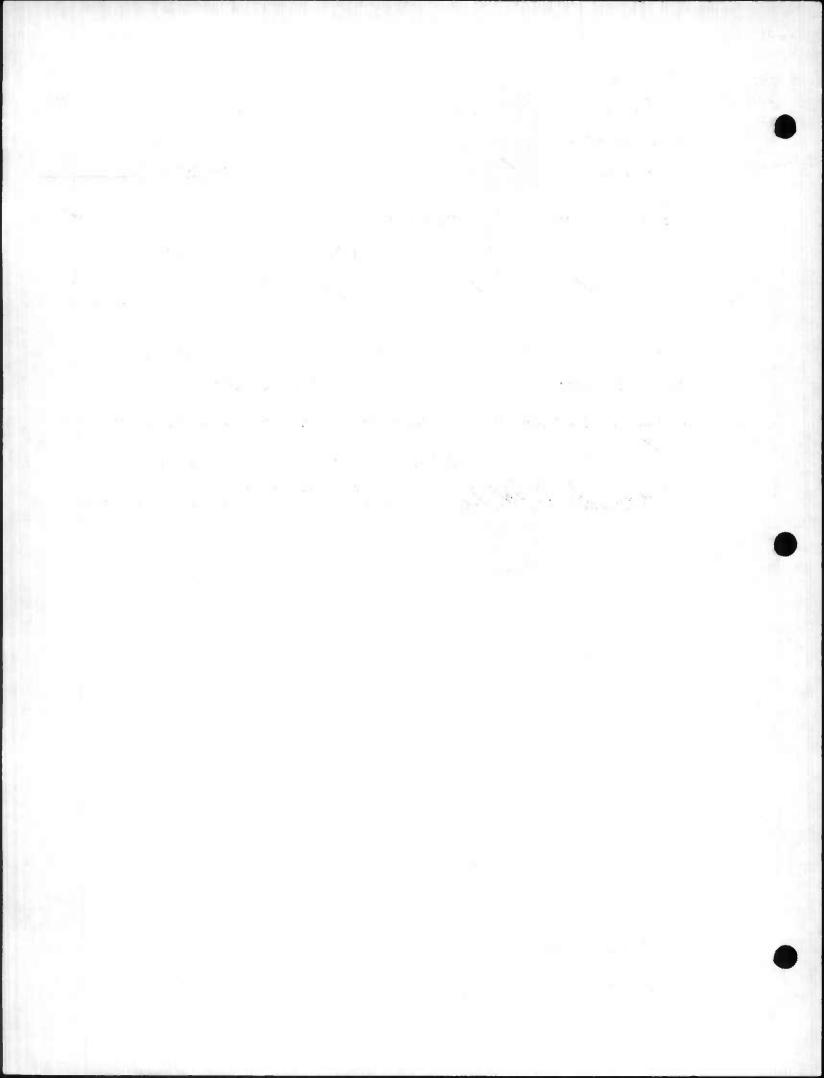
29d. Data signed (Month, Dey, Year)

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

WENGUSA NAVARRO, MD 100 N. BROADWAY, 31. Dete filed (Month, Dey, Year) SEP 2, 2, 1998

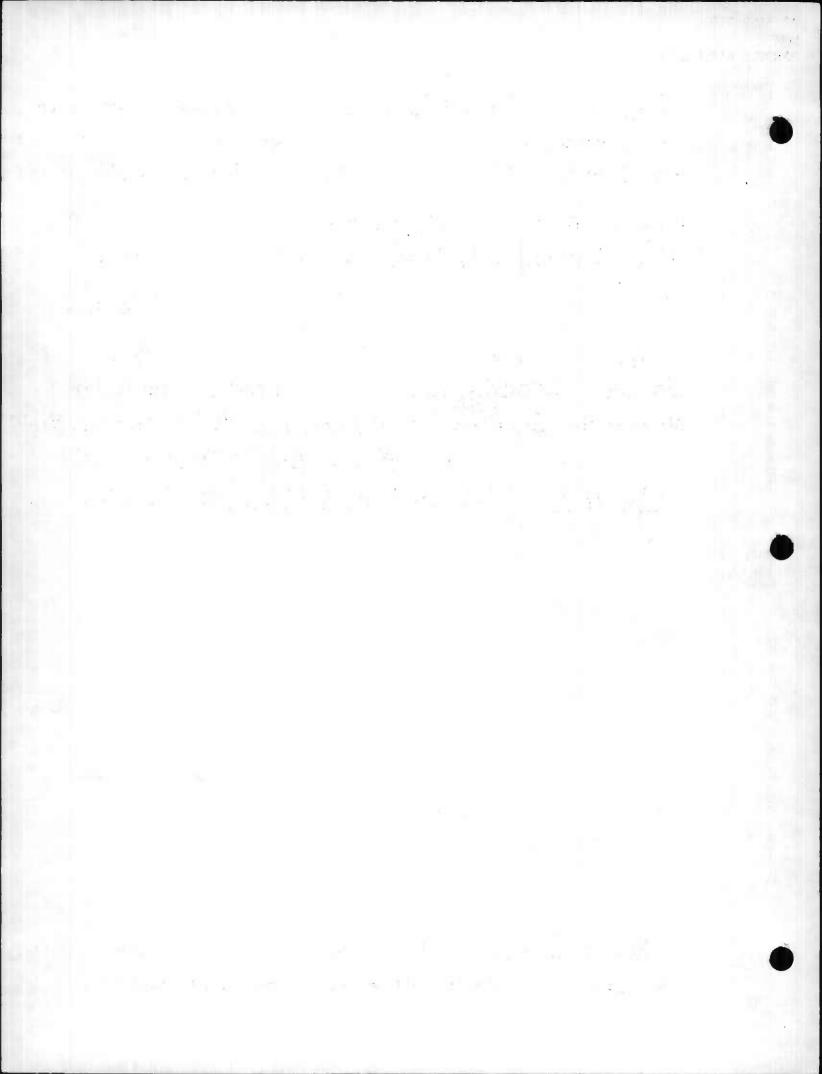
32. Régistrer's Signeture

State Registrar



## Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ITA STAC	#2	OUSE 3 PART [, 27 PER M] 1. Decedent's Name (First, Middle, Las		-98 Certifica	te of Death	Re 2. Dete of Death	0	3 28 S	22 me of Death			
Physic /Medi	cal	Janeta M 4a Facility Name (If not institution, give	1. Stack	house	4b. City, Town, or	Month SEPTEMBE	Day	Year 1998 08	310AM			
Exami	ner	UNIVERSITY HOSPIT	Carlos and No.		BALTIMORE		70. 000111	11/ A				
Funeral Director		5. Sociel Security Number 6. Se		last birthday) If Und Month	er 1 Year If Under 24 Hrs	8. Date of Birth	Year) 1998	9. Birthplace (S	itate or Foreign			
Menyland a-f show	tor	10a. State 10b. County	10c. Ci	y, Town or Location	nre.	/			Ide City Limits  KYes 2□ No			
effer deeth with the Merylen or frems 23a or 28a-f show in her mast be not fred at	ai Director	10e. Street and Number 3100 Auche	ntoroly T	errace	21217	10	g. Citizen of V	Whet Country?				
	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorcad	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	If Yes, sp	edent of Hispenic Origin? (Secify Cuban, Mexican, Puen 2 DNo Specify:	pecify Yes or No- to Ricen, etc.)		e - American Indi ck, White, etc.	an,			
"natural",	ted	15. Decedent's Edi (Specify only highest grad	ication	16a. Decedent's Us	ual Occupation work done during most of wo	rkina 1	6b. Kind of Bu	usiness/Industry				
yiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	use retired)		N	A				
Mental Mental arked o	To Be	17. Fether's Name (First, Middle, Last)  Jason  S	tackhou;	se	Arr	ne (First, Middle, M	Jac	Kson				
1 end 2 sho Heelth end em 27 is m ther traum		19a. informant's Name/Relationship (T	рө, Print) (mother) Jackson	3/00 A	ss (Street end Number of Ri	ral Houte Number,	City or rown,	Flor Balt	Md.2121			
if the		20a. Method of Disposition  1 X Burial 2 Cremation 3 4 Donetion 5 Other (Specify,	Removal from State	Place of Disposition (A remetery, crematory of	ame of rother place)	9/23/98 2	Balt	City or Town, St	ate d			
permit. Pa Depertmen Important: any injury once.		21. Signature of Funeral Service License	Jyp,	Joseph Joseph	and Address of Facility	Funer	ab H	ome	2121/			
		23a. Part 1 Error the diverse, or composhoo or heart fairure. Lest only c	lications that caused the deat ne cause on each line.	h. Do not enter the m	ode of dying, such as cardia	c or respiratory arre	est,	Interv	el Between t and Death			
Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in deeth)	a. SUDDEN INFA	NT DEATH S								
ficate be executed g physician end as the buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	bDue to (or as a consequence of):									
E 000	Medical	Cause (Disease or Injury that initiated events resulting in deeth) Last	Due to (c	r as e consequence o	·):							
death certifi e ettending j ed for use es	cian	Part II. Other step flesses and blesses as			anno alum in Bod I	12h Did to	haaaa uaa aa	ntribute to the c	ause of death?			
thet the cled by the deteched	by Physician/M	Part II. Other eignificant conditions co	ntributing to death but not res	uiting in the underlying	cause given in Part I.		s 2□ No	3 ☐ Probably				
requires been sign should by	Completed b					24e. Wes ar perform		24b. Were eut aveilable completic of death?	prior to			
0 - 0	E O					10/ve	s 2 No	1 Yes	2□ No			
	Be C	25. Was case referred to medical examiner?			26. Place of De	eth (Check only one	e)					
Phys this ral di	2	1 ⊠ Yes 2 □ No  27. Manner of Death 1 1 Naturel 5 □ Pending	Hospital: 1 ☐ Inpatient 2 ∰ 28a. Date of Injury (Month, Dey Year)	ER/Outpatient 3 28b. Time of Injury	OOA Other: 4 Nursing I	Home 5 ☐ Reside 28d. Describe ho						
i or Attending P i efter death. I Director: After t d in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Placa of Injury - At h building, etc. (Specif	ome, farm, street, fact		28f. Location (Str City or Town		per or Rural Route	e Number,			
Hospita 24 hours Funera	edicai C		alcian: To the best of my kno ner: On the basis of examina and manner stated.						ause(s)			
vithin X	Me	29b. Signature and title of certifier	0,	6	9c. License number	29	d. Date signe	d (Month, Day, Y	'ear)			
2		30. Name end address of person who c	efful ompleted cause of death (Iter	n 23e) (Type, Print)	O.C.M.E.		SEPTEN	MBER 17,	1998			
		MARIAMOD	1.160 soli		Street, Balt	timore, M	aryland	1 21201				
	ate	SEP 2 2 1998	32. Registrer's Signe	ature								



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth September 21, 1998 **Physician** David Robert Schlee. Sr. 5:15 PM /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not Institution, give street and number) 4c. County of Death **Examiner** Baltimore 4822 Vicky Road Baltimore 8. Date of Birth (Month, Dey, Year) NOV. 3, 1941 If Under 1 Yeer | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) **Funeral** 1 M 2 □ F Months Deys Hours Min 56 Yrs. Maryland 219-38-1060 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any liqury or other traumatic event, the Medical Ensuring must be notified any once. the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Baltimore Directo Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 4822 Vicky Road 21236 Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11. Marital Status 1 Never Married 21X Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind ot Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Steel 12th Grade Supervisor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Lillian Madeline Freeburger John William Schlee. III 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Interment's Name/Reletionship (Type, Print) 4822 Vicky Road, Baltimore, MD Valerie Anne Schlee (wife) 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 Donation 5 X Other (Specify) Entombment Dulancy Valley Maus. 9/24/98 Timonium, Maryland 22. Neme end Address of Facility 21. Signeture of Funeral Service Licensee Inc. MD Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, 21236 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Death Physician /Medical Immediate Ceuse (Finei disease or condition resulting in death) Examiner Due to (or es e consequence ot): roseti Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequenca ot) Due to (or es e consequence ot): Physician/M 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 3 Probably 4 Unknown 1 Yes 2 No à 24b. Were eutopsy tindings aveilable prior to completion of cause of deeth? 24e. Was en eutopsy performed? Completed 20 No 2 No certificate.? 25. Wes case reterred to medical exeminer? 88 26. Place of Death (Check only one) Hospitel: 1 tnpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Injury et 28d. Describe how injury occurred Lo 1 Yes 2 No 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of Certification: 28c. Injury et Work? Athor 1 Neturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be determined 3 ☐ Suicide 28t. Location (Street end Number or Rurel Route Number, City or Town, State) Pleca of Injury - At home, farm, street, tectory, office building, etc. (Specify) 4 Homicide 8 Hospital 24 hours a 24 hours Funeral 10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) and menner steted. 29e. Certifier Medical (Check only one) To the Partie 2 To the F 29d. Date signed (Month, Dey, Year) 29b. Signatury and Wile of certifier 29c. License number dry/her

DHMH 16 Rev 6/95

Registrar

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30. Name end eddress of person who completed cause ot deeth (Item 23e) (Type, Print)

burton

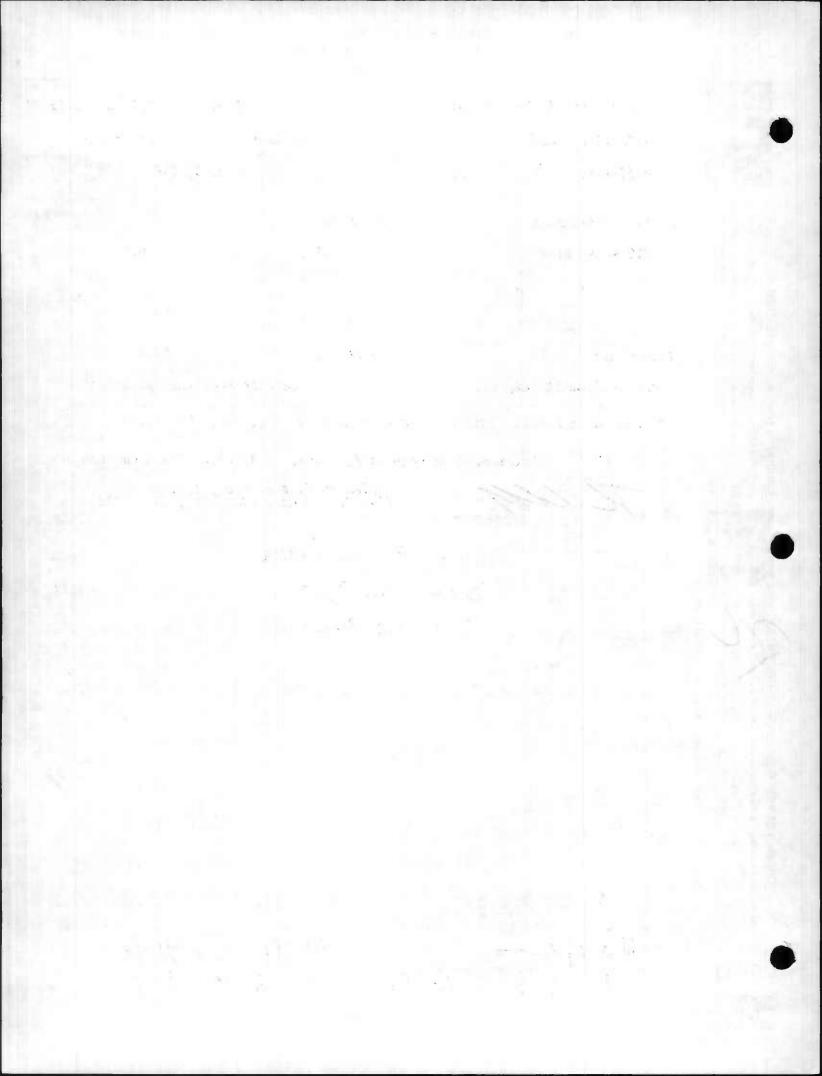
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32. Registrar's Signature

2021

2 2 1998

31. Date filed (Month, Dey, Year)



# Please Type or Prin's in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

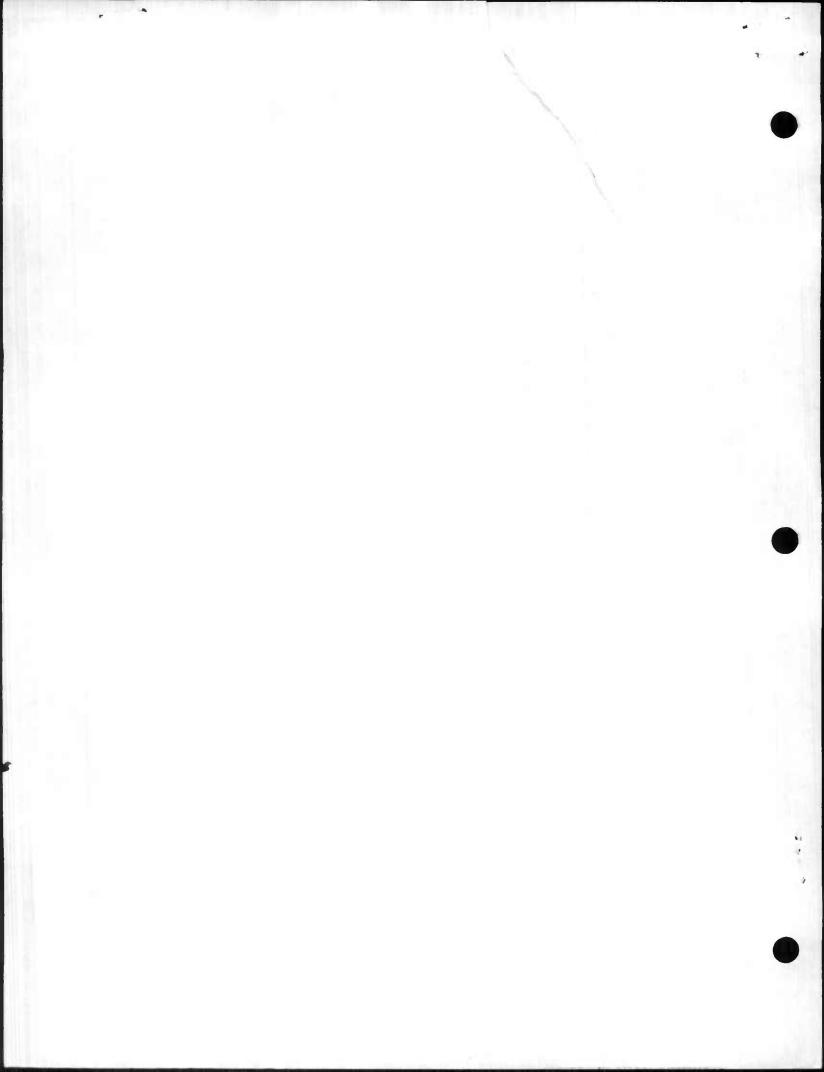
Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death GREGORY D. SUMMERVILLE SEPT. 19 1998 5:50 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 627 EAST 29TH STREET BALTIMORE N/A Months Days Hours Min. 04-03-1951 8. Secial Security Number 7. Age (in yrs. Mat birthday) 9. Richplace (State or Foreign MARYLAND 10 M 20 F 217-52-8419 47 Ynı. **Usual Residence of Decedent** 10c. City, Town or Location 10s. State 10d. Inside City Limits them 27 is marked other than "natural", or thems 23a or 28a-f show other traumatic avent, the Medical Examiner must be notified at N/A BALTIMORE 1 Yas 2 No MD 10e. Street and Number 10f. Zip Code 1/3g. Citizen of What Country? 627 EAST 29TH STREET 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 195/ves 2 No 1969-If Yes, Give Year or Dates: 1974 13. Was Decedent of Hispanic Critrin? (Specify Yas or No. If Yes, specify Cuban, Mexicus, Fuerto Rican, etc.) 11. Maritat Status 14.Race - American Indian Black: White, etc. 1 Never Married 2 Married 1 Was 25 No Specify: 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most di working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 161b.Kinetos Bust ness/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) MACHINE SWEEPER OPERATOR CITY OF BALTINORE YEARS 17, Father's Nama (First, Middle, Last) 16. Mother's Masne (First, Middle, Maiden Sumane) 3 ALBERT D. SUMMERVILLE ANNIE Y. FIELDS 19b. Malling Address (Street and Number of Rural Route Number, City or Dwn, State, ZipGode)) 19a. Informant's Name/Relationship (Type, Print) riant: If Rem 27 I 627 EAST 29TH STREET BALTO., MD. 21218. GLORIA J. SUMMERVILLE(WIFE) 20b. Place of Disposition (Name of cometery, crematory or other place) 20a, Method of Disposition 20c. Location-Oty or Town State 1 Burial 2 Cremation 3 Removal from State GARRISON FOREST VETS. 9-23 Injury 4 ☐ Donation 5 ☐ Other (Specify) OWINGS MILLS, MD. any in 21. Signature of Funerat Service Licenses 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 10 Yes 20 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 No 1 Yes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa State Needlence 6 Other (Specify) Hospital: 1 Inpetient 2 ER/Outpetient 3 DOA 1 Yes 2 No 27. Manner of Death 28b. Time of Injury 28a. Data of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No werst Director: / 6 Could not be 3 ☐ Suicide 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29s. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 100 leted cause of death (Item 23n) (Type, Print). Baltimore 600 Walte

State

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2. Registrar's Signatur

B. Sparks



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Division

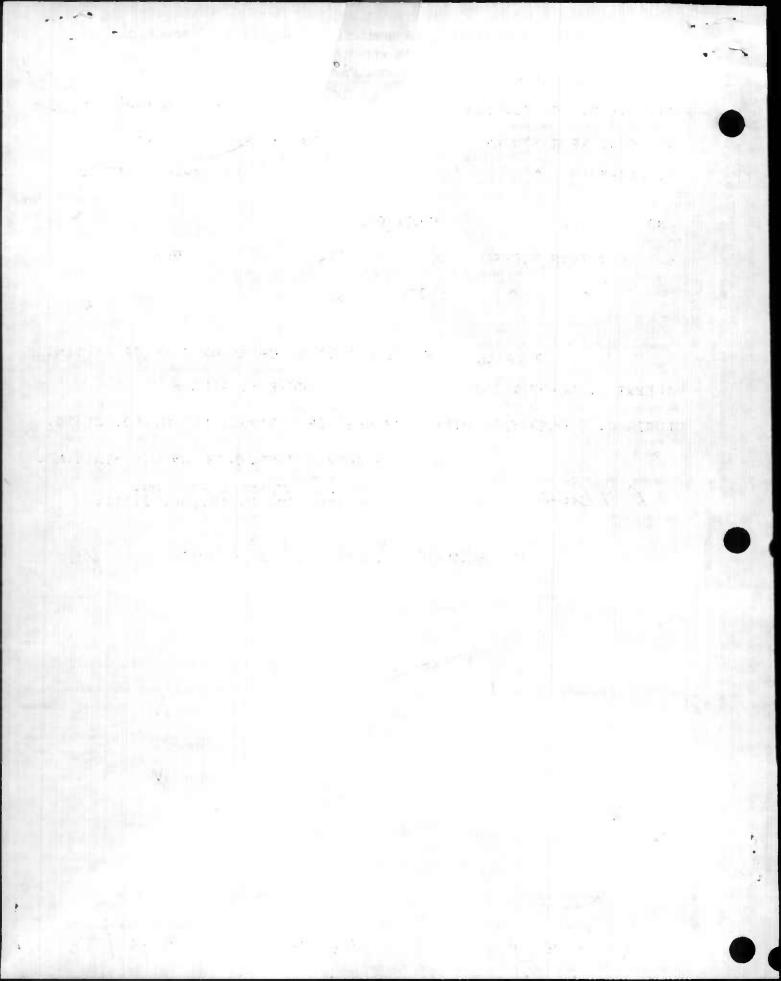
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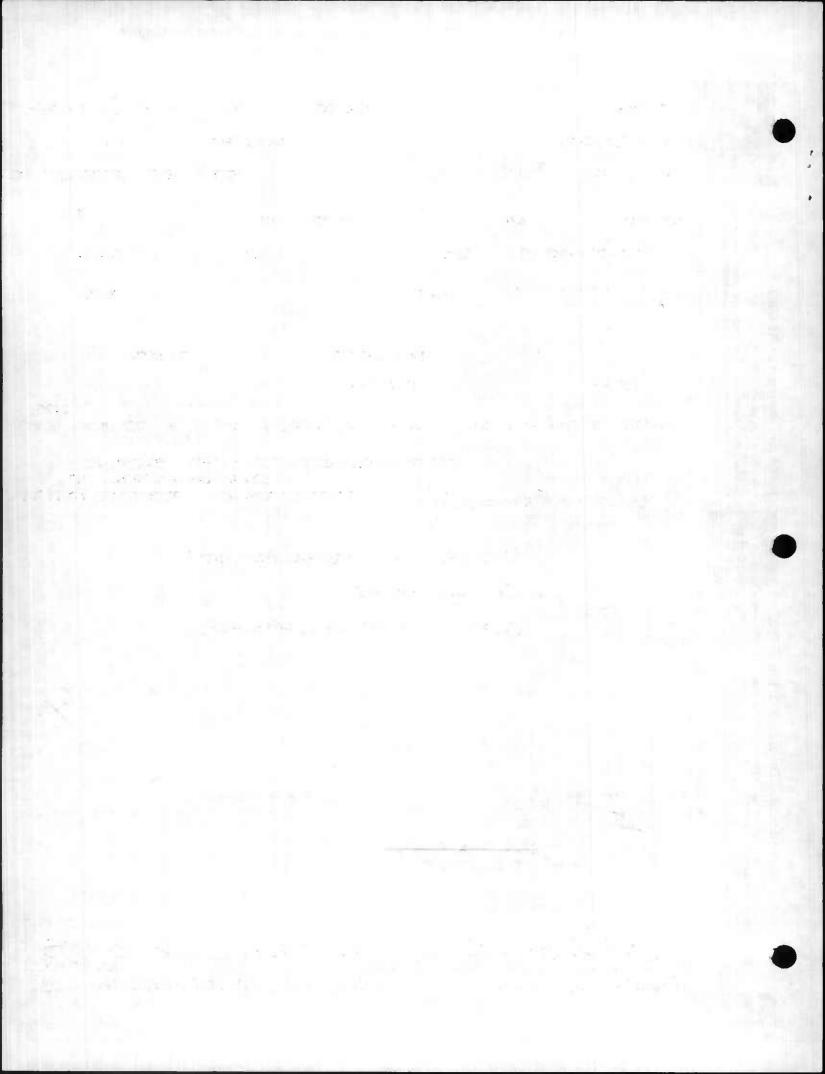
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30. Name end eddress of person who completed cause of deeth (Item 23a) (Typa, Print)



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

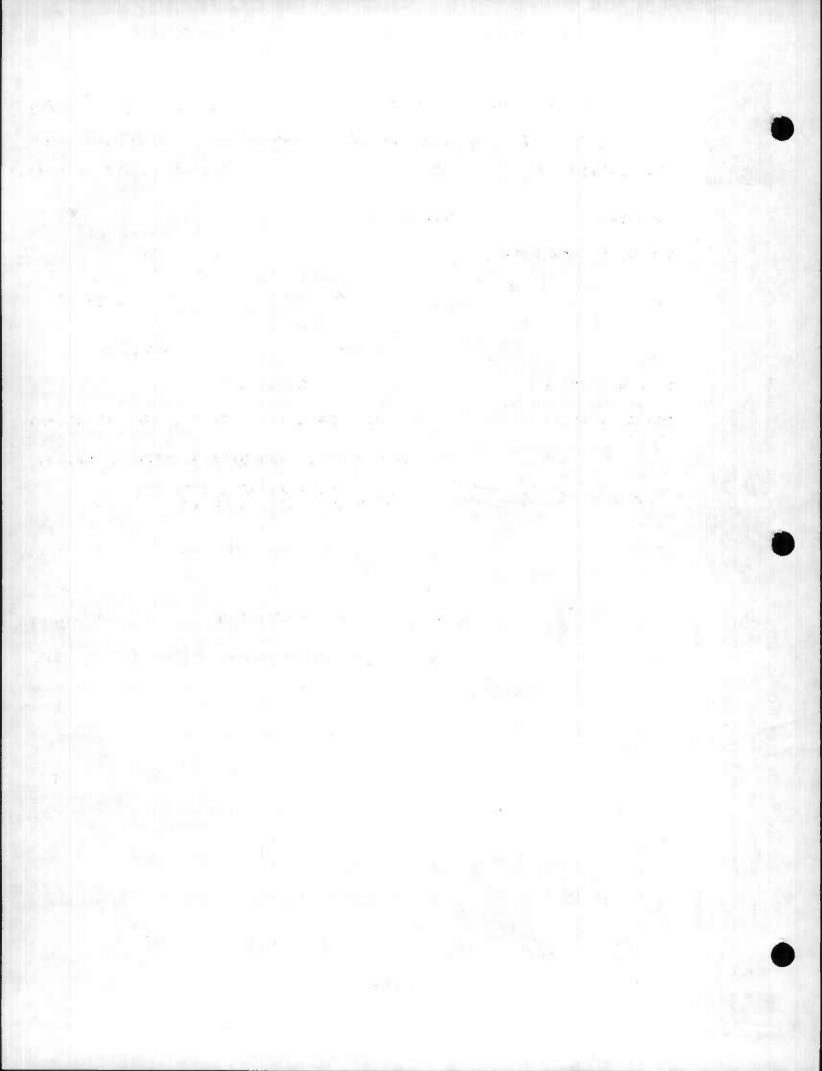
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	217-26- Usual Residence o				/3			JULY 3	, 1925	WASHING	STON, DO		
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Director	NEW YORK		N/	/A		NEW Y	ORK CITY			12(2)	Yes 2□No		
1	10e. Street and Nu	mber				10f. Zip Code			10g. Citizen of V	Vhet Country?			
	26 GRAME	RCY PA	ARK, SOU	TH	APT. G		1000	3		U.S.A.			
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	JOS	EPH			SI	LVERMAN	HENN	IE		LEVY			
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State of Maryland / Department of Health and Mental Hygiene 28926

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Month Year **Physician** SUNSHINE IDA 10:25 AF SEPTEMBER 16 98 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner RANDALLSTOWN BALTIMORE NORTHWEST HOSPITAL CENTER 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) DEC. 15, 1907 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□ M 21 F 90 Yrs. 219-28-7134 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or flame 23s or 28s-f show the Medical Exemples must be notified at 1 ☐ Yes 2 No Director BALTIMORE OWINGS MILLS MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 26 CEDARMERE ROAD U.S.A. deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, Whita, atc. hours efter 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7. I Hygiene. other then "n Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v. Department of Health and Mental Hygie important: if Nem 27 is marked other it eny follury or other traumatic event, the page. 8 HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be DAVIS UNKNOWN **ISADORE** YETTA ETHEL 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26 CEDARMERE ROAD MIRIAM RUTH SUNSHINE / DAUGHTER OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 10 Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) 9/18/98 BNAI ISRAEL CEMETERY BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Fungeral Service Line PIKESVILLE, MD 21208 8900 REISTERSTOWN ROAD 23a, Part1, Ent plustions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, one cause on each line. Approximata Interval Between Onset end Deeth Physician Immediate Cau (Final disease or conduion resulting in death) /Medical SEPSIS Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or as e consequence of): a signed by the a Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, by cate has been sig , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No this certificate Division of Vital al or Attending Physician: The star death.
I Director: After this certificated in by the funeral director, pa 25. Was case referred to medical 8 26. Place of Deeth (Check only one) Hospitat: 1⊠ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 15d Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) K.S.RAO.M.D. 043462 SEPTEMBER 16 98 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K.S.RAO.M.O HOSPITAL CENTER RANDALLSTOWN NORTHWEST 31. Date filed (Month, Day, Year) 22. Registrar's Signature State SEP 2 2 1998 Registrar

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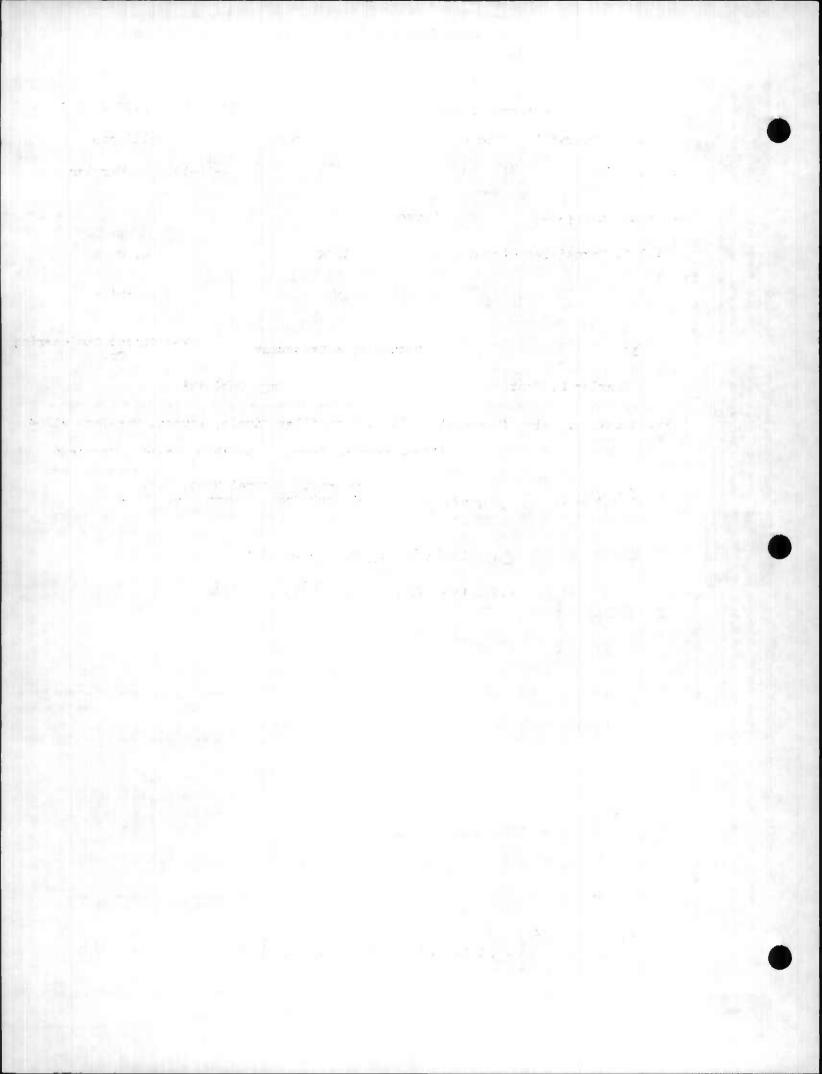
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Death 3 Time of Deeth 1. Decedent's Nama (First, Middla, Last) Month Dey Year September 19,1998 **Physician** 4:00 AM Charlotte P. Smith /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 113 B. Versailles Circle Towson Baltimore If Under 1 Year if Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 4-30-1929 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foraign **Funeral** Days Hours Min 1 M 2 TF 69 219-22-3748 Yrs. Maryland Director Usual Residence of Dacedant with the Maryland r 28a-f show 10e. State 10b. County 10c. City, Town or Location 10d. insida City Limits 1 Yas 2 No Towson Baltimore Directo Maryland 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Coda "natural", or items 23a or address Example or 113 B. Versailles Circle 21204 U. S. A. death Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Rican, etc.) Race - Amarican Indien, Black, Whita, atc. 11 Maritel Stetus permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other tranmetic event, the Medical Evant 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 ☐ Yas 2 No Specif White þ 3 Widowed 4 Divorced Completed 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16h Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) The States Engineering Secretary & Treasurer 17. Father's Nama (First, Middle, Last) 18. Mother's Nema (First, Middle, Meiden Sumama) Charles L. Punte May Debinski 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) 19e. Informant's Name/Ralationship (Type, Print) 113 B. Versailles Circle, Towson, Maryland 21204 Mr. Gerald M. Smith (Husband) 20a. Method of Disposition 20b. Placa of Disposition (Name of Data 20c. Location - City or Town, Stete Hilltop Service Corp. 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from Stata 9-21-98 Towson, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funaral Servica Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 23a. Pert1. Entar tha disaasa, or complications that caused the death. Do not antar the mode of dying, such as cerdiac or raspiratory errast, shock, or heart failure. List only one cause on each line. 1050 York Road, Towson, Md. 21204 Approximeta Intarval Batween Onsat and Death **Physician** Immadiate Ceuse (Final disease or condition rasulting in death) /Medicat CONGESTIVE HEADT **Examiner** Dua to (or as a consequance of) THE WING Physician/Medical Examiner i, P.O. Do. ARCINO MB OF Sequantially list conditions, if any, laading to immadiata ceusa. Entar Underlying Causa (Disaasa or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Dua to (or as e consequença of): SE 080 the Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? 1 No 3 Probably 4 Unknown signed b p requires Completed 24a. Was en autopsy 24b. Wara autopsy findings available prior to completion of ceuse of death? performad? certificate has b The law 1 Yes 2 No 1 ☐ Yas 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was cesa refarred to medical axaminar? Be 26. Place of Death (Check only ona) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Aesidence 6 Other (Specify) 1 Yes 2 No 2 Certification: 27. Mannar of Death 28b. Time of 28d. Dascribe how injury occurred 1 Matural 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accident 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 3 Sulcide 6 Could not be determined 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 Homicida 1 Cartifying Physicien: To the best of my knowledge, deeth occurred at the tima, data and place, and dua to the causa(s) and mannar as stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, data and place, and dua to the causa(s) edicai 29a Cartifier end menner stetad. 29b. Signatury 29c. Licansa number 29d. Data aigned (Month, Day, Year) 30. Name and address of person who completed ceusa of daath (Item 23a) (Type, Print) DT/STE 408 505 235 CASUS LARCIO 31. Data filad (Month, Day, Yaar) 32. Registrar's Signatura Deneva Registrar

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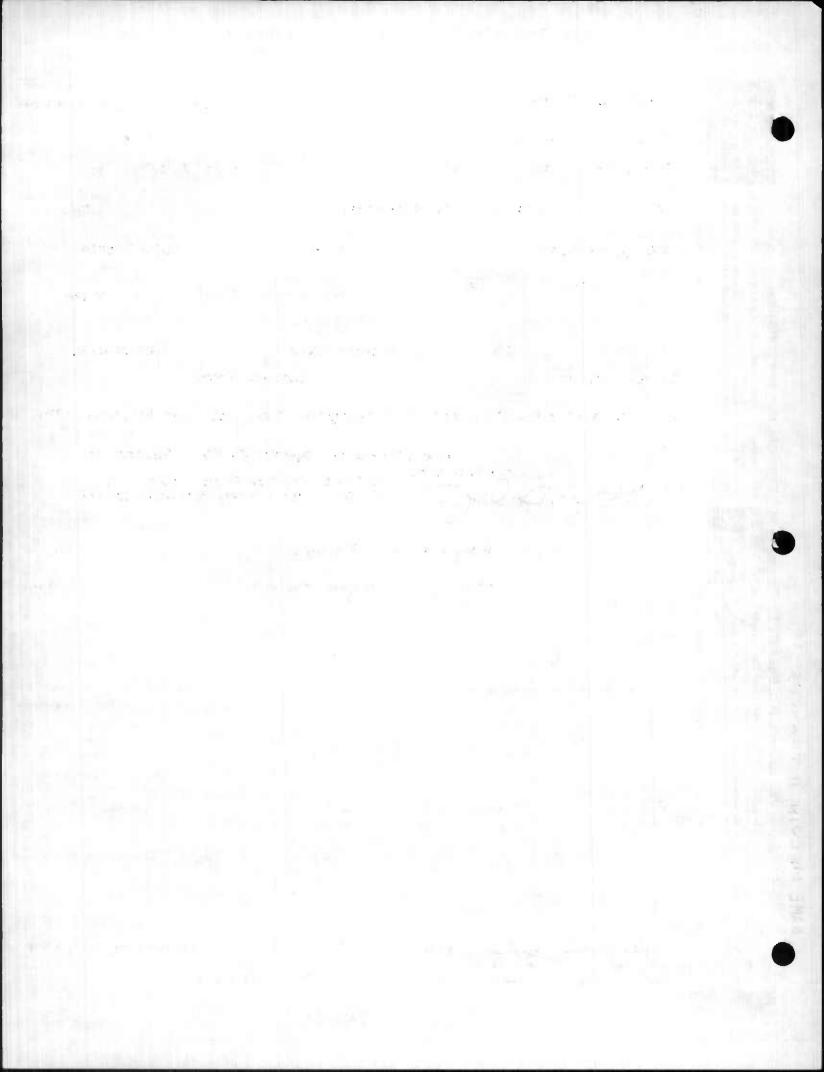
State of Maryland / Department of Health and Mental Hygiene

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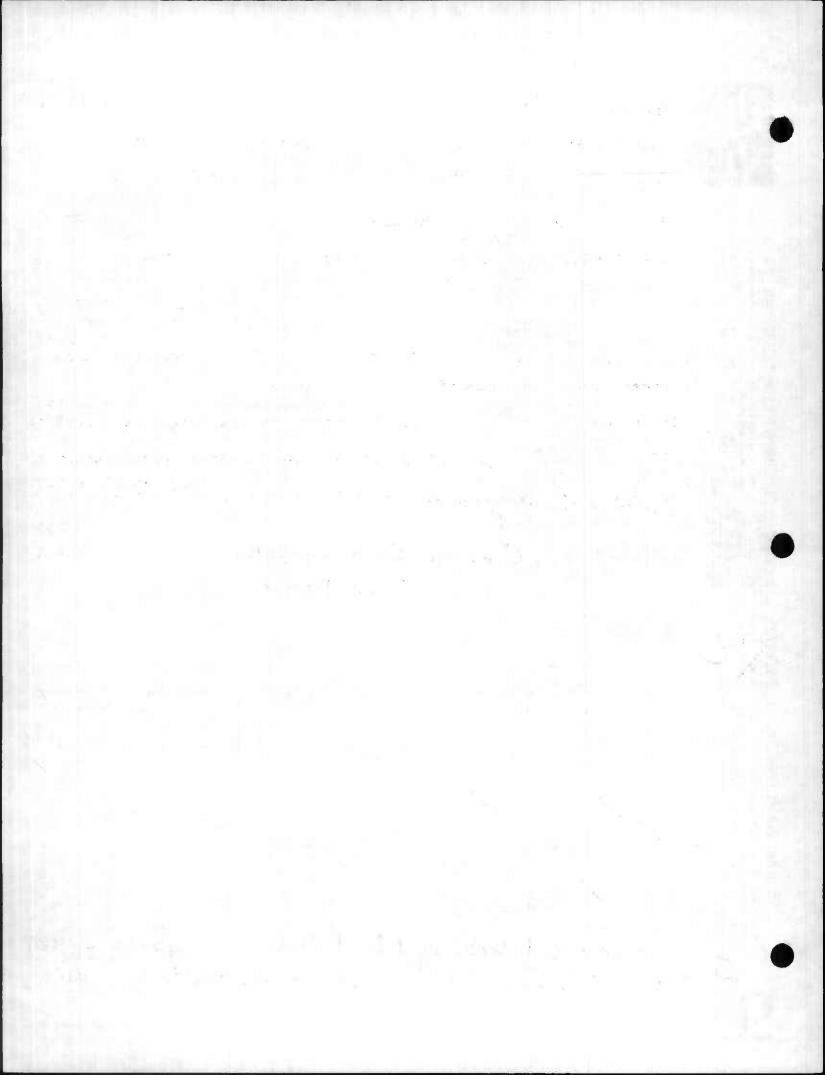
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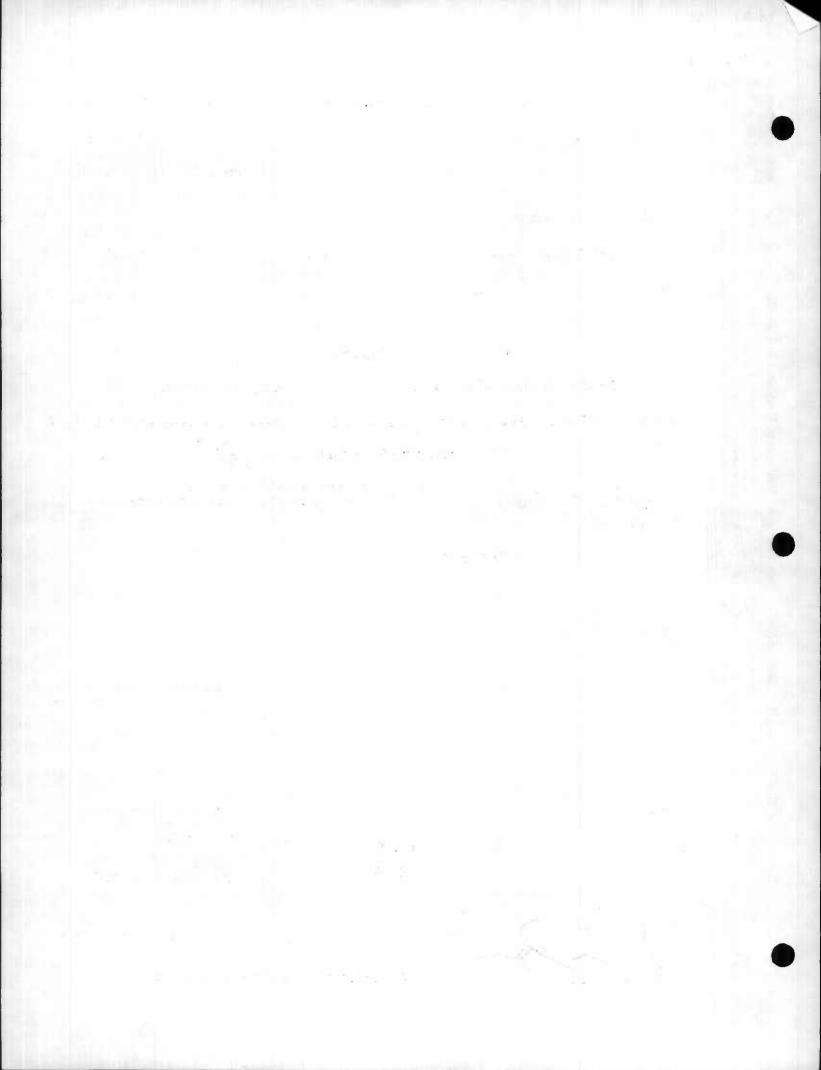
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#5 Per FH Film (	G763 9-23-98RC	State of	Marylan		rtment <i>tificate</i>			nd M	ental Hy	giene Reg. No.	28	931	
Physician /Medical	1. Decedent's Nama (First, Middle, Last) Audrey D. Taylor								2. Date of Death  Month Day  Or Location of Death  4c. County of Death				
neral 5. Social cector 213	ity Nama (If not institution, iberty Med Security Number 636-1561 asidence of Decedent		Baltin				imo	8. Data of Birl (Month, Da	NA		ice (State or y)	e (State or Foreign )	
10e. Sta	te 10b. County			, Town or Loc			-				10	d. inside City	
MI 10e. Str	eet and Number		246-D	timor	101. Zip (	ode	1			10g. Citizen of W	Vhat Counti	45.45	
11. Mari	21 Windsor tal Status Navar Married 2⁄ Married Widowed 4 □ Divorced	12. Was Deced	ant Ever in U, es? [k]No	If	21207  13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Maxican, Puerto					USA 14. Race Black Specify:	e - Americe k, White, e		
Eleme	15. Decedent's (Specify only highast Intery/Secondery (0-12) h Grade er's Name (First, Middle, Le	or 5+)	life. D	ent's Usual kind of work OO NOT use	dona d	luring most			16b. Kind of Bu  Berna  Maiden Sumem	siness/indu	stry Bui	ldin	
Gr	eenburry	ward				Iren	е		Dors	ey			
20a. Me	Dolly Martin  20a. Method of Disposition  20b. Place of Disposition (Name of cometery, crematory or other place)  20b. Place of Disposition (Name of cometery, crematory or other place)  King Mem. PK. Cem. 09-25-98 Randal  21. Sgnature of Funeral Service Decree  22b. Place of Disposition (Name of cometery, crematory or other place)  King Mem. PK. Cem. 09-25-98 Randal  22c. Name and Address of Facility  WM.C.March FH 1101 E. North A										City or Tow alls rvla	m, State town , nd 21	MD
disasseresulting  Sequentification  Sequentification  Sequentification  Ceuse.  Ceuse.  Ceuse.  Ceuse.  Ceuse.  Ceuse.  Ceuse.  Ceuse.  Ceuse.  Ceuse.  Ceuse.  Ceuse.	ate Cause (Final or condition g in death)  stially list conditions, seding to Immediate Enter Underlying Disease or Injury ated events In death) Last	a. Con b. Cor c.	Due to (or	as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a c	uence of):	De	seas	ath	γ			Year	/S
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29a. Ce (Cl or	Homicide determin	ad 200. Place U	s of examinat	vledge, death	occurred a	the tim		d place, a	City or To	vn, State) cause(s) and ma	nner as sta	ated.	
29b. Sig	nature and title of certifier  Leoge (	1. Wi	le d	X M,			number 136	,5		29d. Data signad Septemb W A	d (Month, E	20, Year)	198
G	a and addrass of person when the course E. W. filed (Month, Day, Year)	ocompleted ceuse		),	260	00	Libe	wty	Heig	buts AI	Je,	2121	15



State of Maryland / Department of Health and Mental Hygiene 2 8 9 3 2

Sα	MILTE 1	.11	GHMAN					Certifica	ate of	Death		Reg. No.	his		Liqui
п			1. Decedent's Nama (First, A	fiddle, La	ist)			Tell			2. Data of De	ath Day	Yaar	3. Time of	Death
	Physicia Medic/				Scottie	Phil!	ip T	lilghma	n,Jr.		Sept.	18, 199	8	5:45	p.m.
Δı	Examin		4a Facility Name (If not insti	lution, giv	re street end numbe	er)				4b. City, Town, or	Location of Death	4c. County	of Death		
			3000 Alab							N/A			timor		
	Funeral Director		5. Social Security Number unk.		Sax 7.	Age (In yrs		rs. If Und	ler 1 Yaar s Days	If Under 24 Hrs Hours Min				olaca (Stata o ntry) Cyland	ir Foraigi
	Du	-	Usual Residence of Deceder 10a. State 10b. Co			10c. C	ity. Town	or Location					- 1	10d. Insida Ci	ity Limits
	-f aho	rol		ltim	ore				N/	A				1 🗆 Yas	
	7 28a	Funeral Director	10e. Street and Number					10f.	Zip Code			10g. Citizen of \	What Coul	ntry?	
-	38 0	0	3000 A	laba	ma Ave.				212	27		U	S.A.		
	0000	ner	11. Marital Status		12. Was Decede Armed Force	nt Ever in l	J,S.	13. Was De	cedent of h	dispanic Origin? (	Specify Yes or No rto Rican, etc.)	14. Rac	e - Americ	cen Indian,	
2-0020	filed within /2 hours enter death with the maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Evarrings inset be notified at	by	1 Never Married 2 □ 3 □ Widowed 4 □ Divo		1 Yes 24 If Yes, Give 4	No			2√2 No	Specify:	ito i induit, oto.,	Specify		nite	
	natural',	Completed	15. Dec	edent's E	ducetion ade completed)		16a.	Decedent's U	sual Occup	etion during most of we	orkina	16b. Kind of B	usiness/in	dustry	
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>	should nd Mer marke imetic	2	19a. Informant's Name/Rala		hillip Ti	riginik			es /Street		y Ann Wa Bural Route Number		State 7in	Code	
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נו ע	Heal Heal tem 2		20a. Method of Disposition	-F 1	119mmmi,	20b.	Place of	Disposition (f	leme of	wate Ave	Data	20c. Location			
Calculo	rages net of l int: If its iry or o		Burial 2 Crema 4 Donation 5 Other					ridge			Sept.23 1998	Elkride	ro M	53	
			21. Signature of Funeral Ser					22. Name	and Addre	ess of Facility	1990	DIKLIG	je, n		
	Departimonts any injuries.		//	_	111.			McCu]	ly-Po	olyniak	Funeral :	Home			
	Physician /Medical Examiner	ler	23a. P-m1. Enter the disaas shock, or heart failure.  Immediate Cause (Finat disease or condition resulting in death)	List only	a. SMOKE	INHA	LATIC							Interval Bet Onset and I	Death
	in Tand	Examine	Sequantially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury	ſ	b	Due to	or as a c	onsequence o	of):				t		
	ndifficete be exemple on the physician as the burial-	Medical	Cause (Disease or injury that hitlated events resulting in death) Last	1	C	Due to (	or as a co	onsequence o	f):						
	death cert he attendin	Physician/	Part II. Other algnificant cor	ditiona	d	n but not re	sulting In	the underlyln	g causa gh	van in Part I.	23b. Did	lobacco use co	ntribute t	o the cause	of death
	net me de sed by the a deteched (										10	Yes 2 No	3 Pro	bably 4X	Pnknov
	been sign should be	Completed by										an autopsy med?	av cc	fere autopsy vailable prior to ompletion of death?	to
- 3	0 - 0	E									10	Yes 2000	1	☐ Yes 2☐	No
		0	25. Was cese referred to me	dicel						26. Place of De	eath (Check only o	one)			
	0 0	To B	examiner? 1XX es 2 No		Hospital:	atlant 2	ER/Out	patient 3	DOA Oth	her: 4 Nursing	Home 5 Resi	dence 8 Oth	ner (Speci	ify)	
			27. Manner of Death  1 Natural 5 Pe	ndina	28a. Date of I (Month,	njury Dev Year)	28b. T	ime of jury	28c. Inju	ry at		how injury occur	rred		
	Attending or deeth. ector: After by the fune	äti	2/2 Accident in	estigatio	9-18-9			50 P M		Yes 2 No	HOUSE	FIRE			
	rected in by t	Certification:		termined	286. Place of	Injury - At I etc. (Spec	in el	m, street, fac HOME	ory, office		28f. Location (	Street end Numi vn, Stete)	ber or Run	al Route Num	iber.
3	ra af Died											ABAMA A			
	to the hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifier (Check only one)	itying Ph Ical Exa	nyalcian: To the be miner: On the basis and manner	s of axamin	owledga, ation and	death occurr for investigat	ed at the ti on, in my o	me, data and place opinion, daath occ	a, and due to the surred at the tima,	cause(s) and m data and place,	anner as s and due t	stated. to the cause(s	s)
1	Mithin Somp	Me	29b. Signature and title of pe	filler	)				29c. Licens			29d. Data signe			
			MA (		2				O.C	.M.E		SEPT.	19,	1998	
)	5		30. Name and address of pe		complated ceusa c	of death (Ite	m 23a) (1	Type, Print) Penn S	treet	, Baltim	pore, Mar	yland 2	1201	-12	1 P SAME
	Ste	to	S Committee Harrist Annual Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee Committee	CAN DECEMBER	32. Regi	istrar's Sion		1	onk			-	-		
	Sta Registra	ar	31. Date filed (Month, Day )	2 199	18		1	· In	man						



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Tima of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Day Physician SEPT. VISOTSKAYA 17, 1998 1:51 AM MERA /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A SINAI HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M XXF Months Days Hours 217-92-7152 Yrs 88 Director AUG. 5, 1910 UKRAINE Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show notified at 1 ☐ Yes 2X No Directo MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 7 is marked other than "naturel", or items 23a or traumatic event, the Medical Examples must be a 7920 SCOTTS LEVEL ROAD 21208 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health end Mental Hygiena.
nt: if Item 27 is marked other then "naturel", or items 23 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Yeer or Detes: 14. Race - American Indien. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: à WHITE **3**O‱idowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) CLERK HOSPITAL 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) **AURAHAM MEDVEDEV** BASHEVA SUDAKIN 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health e Important: If item 27 is any injury or other trai ARKADY VYSOTSKY / SON 2305 MELLOW COURT BALTIMORE, MD 21209 Ob. Placa of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Commation 3 ☐ Removal from 9/18/98 BETH EL MEMORIAL PARK RANDALLSTOWN, MD 5 Other (Specify) 4 Donation 22. Name and Address of Facility any in SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 callions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, no cause on each line. 23a. Pert 1. Enter the disease, ok co shock, or heart failure. List on Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) riviedica Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) Box 68760, physician The law requires that the deeth certificete be Physician/Medicai Due to (or as a consequence of): 88 USB 23b. Did tobacco use contributa to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. the signed by to 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to 24a. Wes en autopsy performed? Completed peed completion of cause of death? certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 201 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funaral 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Menner of Deeth 28c. Injury at Work? 28b. Time of Certification: After 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No death. investigetion 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by aftar 4 Homicide n 24 hours a Hospital edicai 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated. plately (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. within 2 29b. Signature and title of opetid 29c. License number 29d. Date signed (Month, Day, Year) 0 D76220 September 17, 1998 30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print) 8630 Liberty Plaza Mall Randallstown, MD 21133 Jerome H. Ginsberg, M.D. 31. Dete filed (Month, Day, Year) SEP 2 2 1998 32. Registrer's Signature

DHMH 16 Rev 6/95

Registrar

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth 21 Howar 4a Fecility Name (If not institution, give street and number) Ong Steep, mel Rose 5. Social Security Number 6. Sax, 7. Aga (In y 4b. City, Town, or Location of Deeth 4c. County of Death Bal AVENUE yrs. last birthday) If Under Months timore If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplaca (Stata or Foreign 7. Aga (In yis. last birthday) 12M 2□ F Deys 73 Hours 220-18-7262 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits BAltimore 12 Yes 2 No ma 10f. Zip Code 10e. Street and Number 10g. Citizan of What Country? 21212 AUE, USA BELLONA 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuben, Mexican, Puerto Ricen, etc.) 12. Was Decedent Ever in U,S. Armed Forcas? 1 Yes 2 No Army If Yes, Giva 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify JACK 3 Widowed 4 Divorced Year or Dates: 1950 -15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) CIERK 8 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fethar's Name (First, Middle, Last) RESSIE 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WiFE EUELYN 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Data Buriel 2 Cremation 3 Removel from State 9ESANT REST 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset end Death Immediata Cause (Final etas disease or condition resulting in death) arcomona Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Esophageal Reflux Dispuse 24b. Were autopsy findings evalleble prior to completion of causa of deeth? 24e. Wes en eutopsy Tubercularis Treatment BPH 210 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Wes cese referred to medical axaminar? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 5 Pending investigation 1 Milatural 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

pue Division of Vital Records, P.O. Box 68760 signed by t certificate Hospital or Attending Physician: this funeral After To the Hospna.
within 24 hours effer death.
To the Funeral Director: Al death.

**Physician** 

/Medical

Directo

Funeral

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Completed

Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic avent, the Madical Examination must be notified at

ond Mental Hygiene.

Department of Health Important: If Item 27 i

**Physician** /Medical

Examiner

Physician/Medical Examiner

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Baltimore, Maryland 21215-0020

Medicai

State

Registrar

SchWARTZ

4 Homicide

29b. Signature and title of

at address of par

29a. Certifier

manifo completed cause of death (Item 23a) (Type, Print) 115 E. Melzose Are M.D-32 Registrar's Signeture

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Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

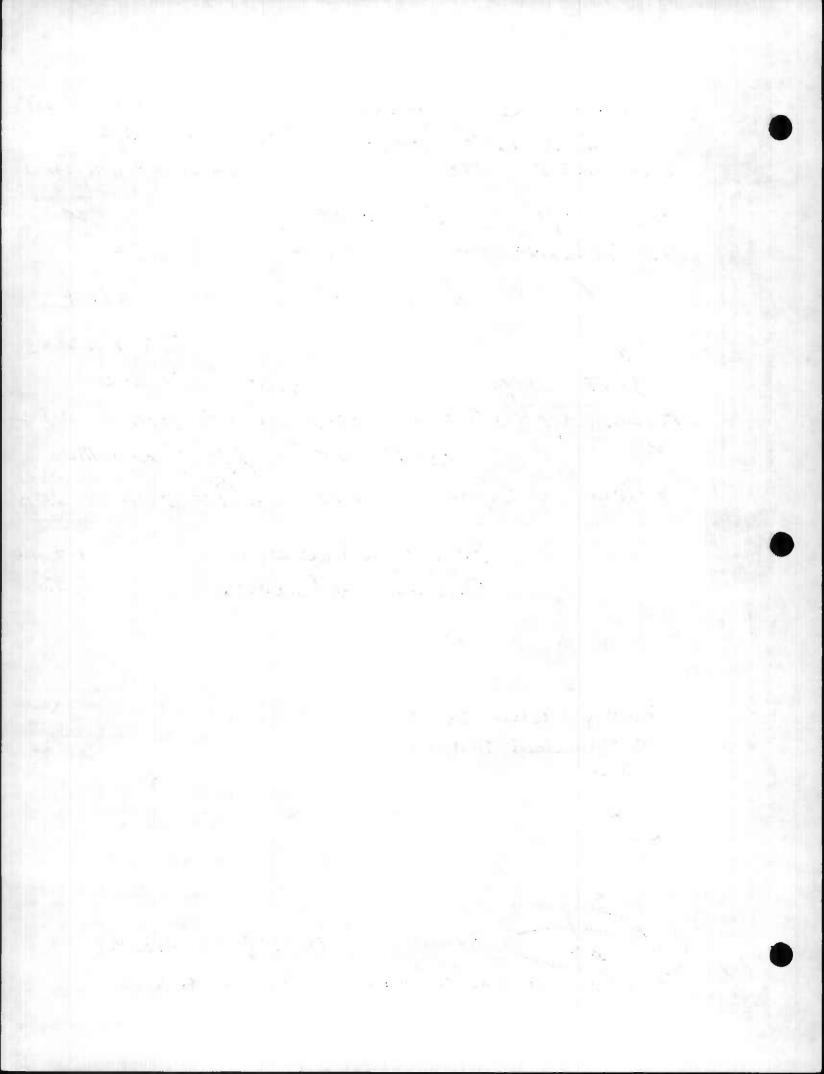
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licansa number

29d. Date signed (Month, Day, Year)

Baltimore Md 21212

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1	30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)  AURORA C TAN MD, 9600 NORTH POINT ROAD, FORT HOWARD, MD		<u>DPIPONBE</u>	TQ_	1. 1339
State Registrar	31. Dete filed (Month, Day, Year) SEP 2 2 1998  32. Registrer's Signeture  Apauls				

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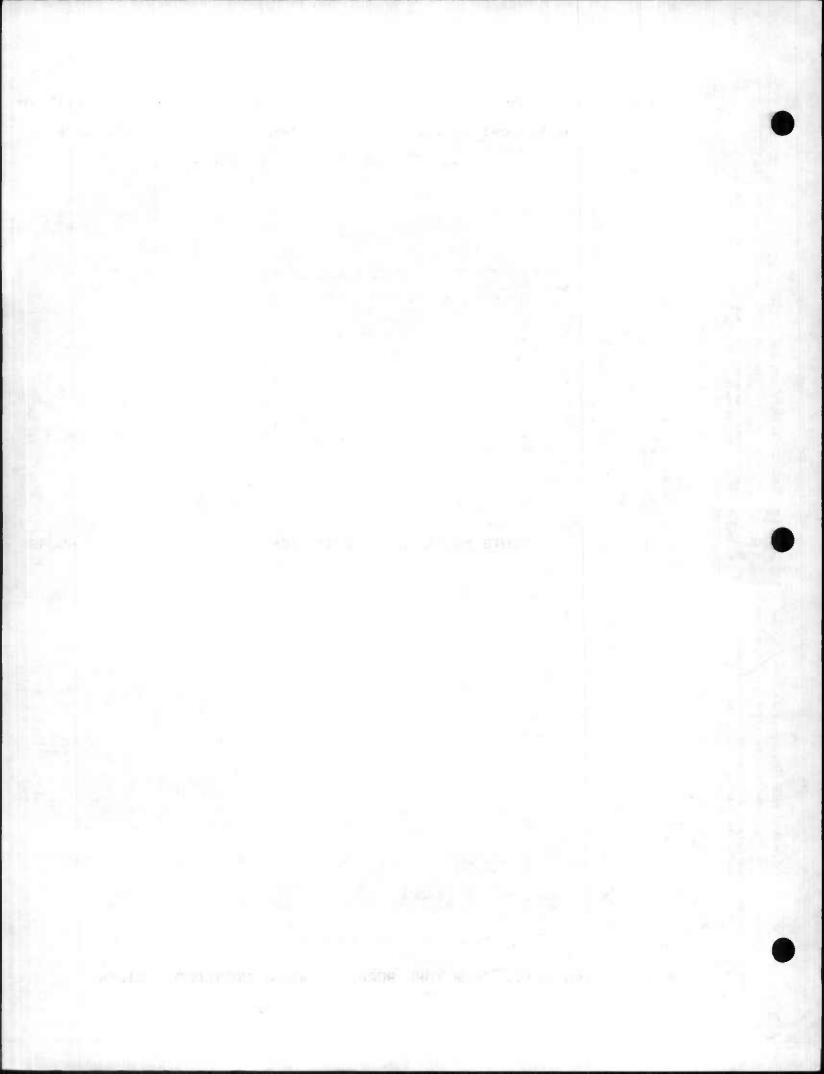
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State of Maryland / Department of Health and Mental Hygiene

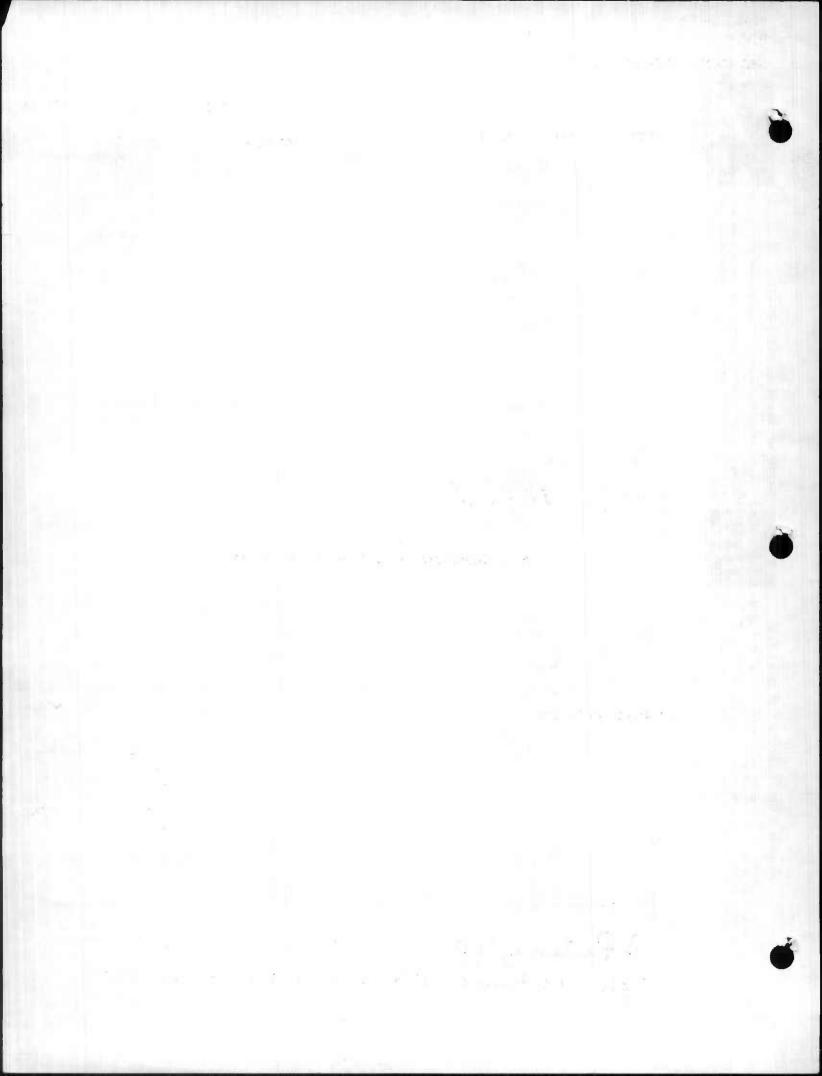
				Certificate	of Death	R	eg. No.	28936
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5-0020 72 hours after death with the Maryland natural', or items 23e or 23e-f show dieal Examinar must be notified at sted by Funeral Director	11. Merital Status  1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Tyes 2 No If Yes, Give Year or Detes:			t of Hispanic Origin? (S Cuban, Mexican, Puer (No Specify:	Specify Yes or No- to Rican, etc.)		e - American Indian, sk, White, etc. y: White
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212 ed within glens. r the M	Elementery/Secondary (0-12)	College (1-4or 5+		Machinist			MArtin	Marietta
Maryland 21215-0020 d 2 should be filed within 72 hours at the and Mental Hygiene. 77 is marined other than "natural", or traumatic event, the Medical Exam To Be Completed by F	17. Father's Neme (First, Middle, La: RUSSell Welty	•			18. Mother's Na	R. Seke		99)
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Sattimore, semit. Pages 1 ar Separtment of Nas ing Injury or other ing Injury or other ings.	20a. Method of Disposition  1 Durial 2 Cremetion 3 4 Donetion 5 Other (Spec		cemeter	Disposition (Name y, cremetory or other S Of Fait	ch Cemetery			City or Town, State
Balt permit Depart Importu	21. Signature of Funerel Service Lic	ensee	1.	Connel	ddress of Facility y Funeral ce AVe. Bal			01
Physician /Medical Examiner	23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Finet disease or condition resulting in death)	ACUTE M	IYOCARI		TARCTION			Approximate Intervel Between Onset and Death 5 HOURS
SX 88760, secured secured section and section and section and section and section and section and section and section and section and section and section and section and section and section and section and section and sec	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	C		onsequence of): onsequence of):				
at the death of the standing enached for use Physician.	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying caus	e given in Pert I.	23b. Did to	obacco uae co	ntribute to the cause of death?
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i Record The law page 2						1 🗆 Y	es 20 No	1 Yes 2 No
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Hospi 24 hour Funer stely fill	29a. Certifier 1 Certifying F	hysician: To the best of eminer: On the basis of e	xamination and	death occurred et ( Vor investigation, in	he time, date end place my opinion, deeth occu	e, end due to the curred at the time, d	ause(s) end me ate and place,	enner es stated. and due to the cause(s)
To the within 2 To the comple	29b. Signature and little of certifier	21	-Ca		icense number Ø263	2	9d. Date signe	d (Month, Dey, Year)
3	30. Name and address of person who	o completed cause of dea	th (Item 23a) (	( ROAD,	TOWSON,	MARYLA	22 70	1204
State Registrar	31. Date filed (Month, Day, Year) SEP 2 2 19	32. Registrar		G. Spa	Ks			

DHMH 16 Rev 6/95



		REBBECCA WILSON ER MEO G764 10-1-98 W		Marylan	•	artment of rtificate			nd Me		giene Reg. No.	3 2	89	37
		1. Decedent's Name (First, Middle, I	ast)						2.	Dete of Dee	eth Day	Year	3. Time	e of Death
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Funeral Director		220-22-1430	1□M 2∏F	7. Age (In yrs 1	Yrs.		Deys	Hours	Min.	Dete of Birth (Month, De) -28-1	7. Year) 923	Cou	ntry) V	te or Foreign a
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3a or		9209 Leigh Choic	ce Court			2111	7				USA			
death	Funeral	11. Meritel Status	12. Was Deced	lent Ever in U,	S. 13.	Wes Deceder	nt of H	ispenic Orlgi	n? (Specif	y Yes or No-		ce - Ameri		1,
or its		1 Never Married 2 Married				1 ☐ Yes 2√		Specify:	rueno nic	an, etc.)		ock, White, by:Blac		
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/Medical Examiner	iner	Immediate Cause (Final disease or condition resulting in deeth)	Arteri		otic (		ase	cular	Disea	ase				
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dclan: The certificate h rector, page	ပိ	25. Wes case referred to medical						OC Disease	-4 Death (	1 1	ΛΛ		☐ Yes	2LJ NO
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Attend or deeth octor: / by the f	100	3 Suicide 6 Could not determine	286. Pieca d	of Injury - At ho	ome, ferm, st	reet, factory, o	office		28	f. Location (S City or Tox	Street end Num	ber or Ru	al Route f	vumber,
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DHMH 16 Rev 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Red. No. 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death Month Day Margaret Julia Wirth SEPTEMBER 19 1998 4:15AM 4a Facility Neme (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE TOWSON GREATER BALTIMORE MEDICAL CENTER 5. Social Security Number 7. Aga (In yrs. last birthday) If Under If Under 24 Hrs. Birthplece (State or Foreign Country) 6. Sax 8. Dete of Birth (Month, Day, Year) 1 M 2 F Min Hours Months Davs PA 95 June 9 1903 219-18-8658 Usual Residence of Decedent 10c. City. Town or Location 10d. inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Baltimore Phoenix 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code USA 38 Glen Alpine Road Phoenix 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black White etc. 1 Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ₩ Widowed 4 Divorcad Year or Dates 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) n/a Homemaker Own Home 11 17. Fethar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Julia Tote Bailis Soltas 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Glen Alpine Rd., Phoenix, MD 21131 Dorothy Heiderman/daughter 20b. Placa of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Qurial 2 Cremation 3 Remove from State 9/22/98 Baltimore, MD Moreland Memorial Park 4 Domation 5 Other (Specify) 22. Name and Address of Facility of Funeral Service Dicenses Hall Lemmon Funeral Home ryan W. Clary 10 W. Padonia Rd., Timonium, MD 21093 friture the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hour failure. List only one of use on each line. Approximete interval Between Onset and Death Sepsis immediate Carrier II disease or condition resulting in death) Due to (or as a consequence of): 45 myelopoche Syndian Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yss 2 No 3 Probably € Unknown 24b. Were autopsy findings available prior to completion of causa of deeth? 24e. Wes en eutopsy performed? 2 No 1 Tyes 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

10

**Physician** 

/Medical

**Examiner** 

10a State

MD

Director

Funeral

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Completed

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**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar most be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of permittent of health and Mental Hygiene.

Maryland 21215-0020

altimore,

P.O. Box 68760,

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death

Examiner Physician/Medical the detach ate has been signed by page 2 should be detac à Completed Be

certificate has Attending Physician: director, this funeral After death. Hospital or Attendit
 24 hours after death
 Funeral Director: A filled in by

10

Certification:

edicai

29e. Certifier

25. Was case referred to medical examiner 1 Yes 2 No 27. Maryler of Death

1 Natural 5 Pending invastigation 2 Accident 3 Suicida 4 Homicide

6 Could not be determined

2 2 1998

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28c. injury at Work? 28b. Time of 1 Yes 2 No

2 ER/Outpatient 3 DOA

28f. Location (Street end Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the bests of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner steted.

29b. Signature end title of certifian

29c. Licansa number

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Othar (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year) 198

nuse of death (Item 23a) (Type, Print) 21284. 30. Name and eddress of person who comp 660 Kenilwort 31. Dete filed (Month.

State Registrar 32. Registrar's Signeture

1 Dinpatient

Dete of injury (Month, Day Year)

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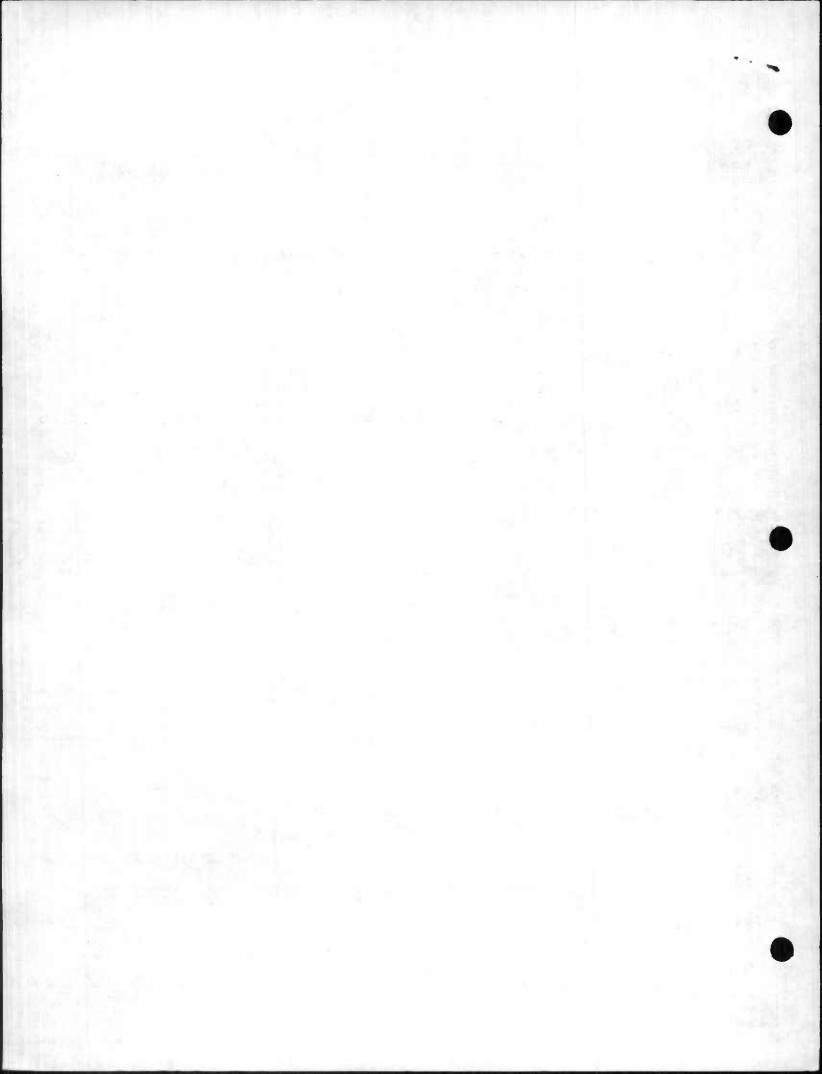
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -1. Decedent's Nama (First, Middla, Last) 2. Date of Deeth 3. Time of Death **Physician** MAJOR LEG WHITE SEAT. 16 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTINIONE Rossiter AUGNUE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** 10 M 20 F Months Days Hours 7-14-7445 Yrs. Director Usual Rasidence of Decedent 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 □ No BALTIMULE Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 534 RUBSITER USA "natural", or Items 23a 21212 12. Was Decedent Evar in U.S. Armed Forcas?

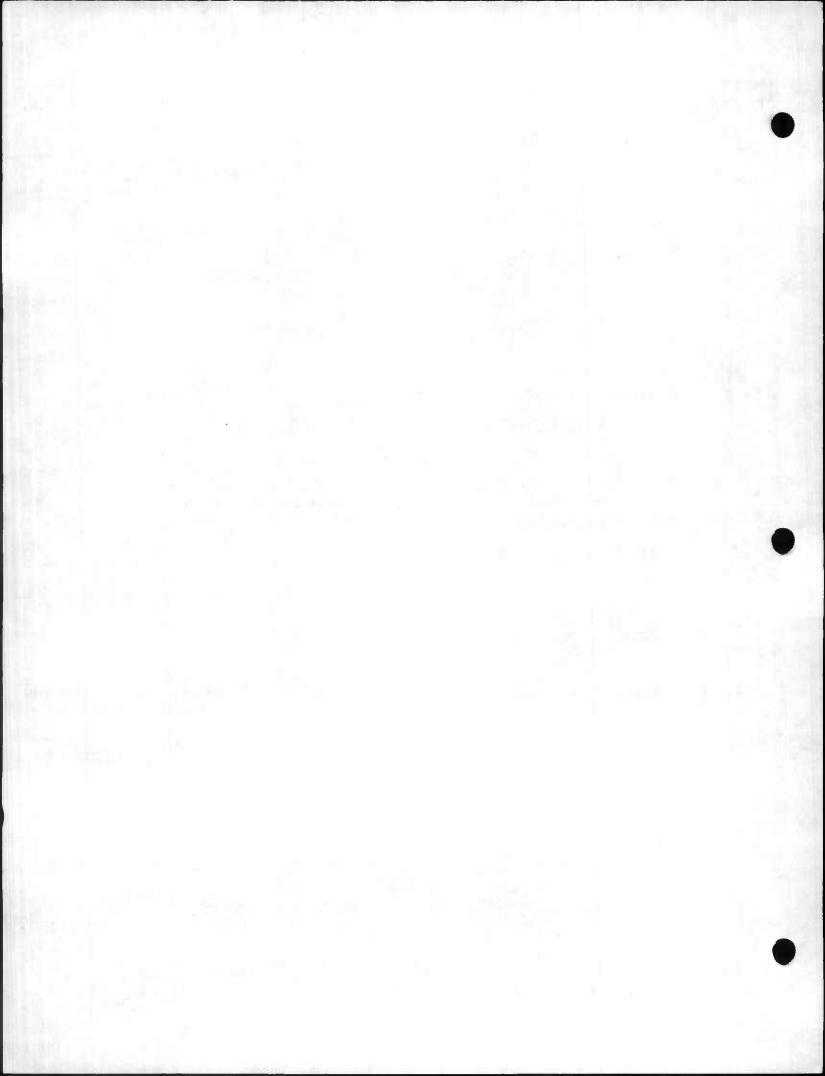
12 Yas 2 No
If Yas, Giva
Yaer or Detas: 14. Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Merital Status 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 MUITE 1 Tes 22 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Harylono Training Elamantary/Secondary (0-12) College (1-4or 5+) louth SUPERUISON 114 GTOCK For Boys SCHOOL Pages 1 and 2 should be filed nent of Health and Mental Hygin ent; If Nem 27 is marked other 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be Whi 650198 19a. Informant's Name/Ralationship (Type/Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Department of Health at Important: If Item 27 is any injury or other trau RUSSITEK AUG BALTIMOTE, Med 2/2/2 white MANIE 20b. Place of Disposition (Nama of cemalary, crematory or other p 20e. Mathod of Disposition 20c. Location - City or Town, Stata 12 Burial 2 Cramation 3 Removal from State 11 HUNIVE, 4 □ Donetion 5 □ Other (Specify) Memiral Borios 22. Nama and Address of Facility CHA TULON -5240 RUSTERSTOWN KURD BALLMUTE, Red 21218 21. Signatura of Funaral Sarvice Licensi 23a. Part . Entur the organs, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hour failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Due to (or as a consequence of) Examiner Sequantially list conditions, if any, laading to immadiate causa. Enter Underlying Cause (Disease or Injury that initieted avants rasulting in death) Last Dua to (or as a consequence of): Box 68760 Physician/Medical Dua to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 No 1 ☐ Yas 2 ☐ No or Attanding Physician: Be 25. Was casa rafarred to medical examinar? 26. Place of Death (Check only ona) examinar?
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10 Natural Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify)
Injury at 28d. Describe how injury occurred Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 5 Pending n 24 hours efter death. 1 Yas 2 No Investigation 2 Accident 6 Could not be datarmined 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifiar completely (Check only one) \$ within 2 To the 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and, NO 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) 654 31. Data filed (Month, Day, SEP 2 2 32. Registrar's Signatura State 2 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene

				C	ertificate	e of I	Death		Reg. No. 9	28940
r	Physician	Decedent's Name (First, Middle, L		V. 1				2. Dete of Dec	ath Day Y	3. Time of Death
Į,	/Medical		LTER				4 65 7		20, 1998	3:18 P.M.
	Examiner	4a Facility Name (If not institution, g. 3700 St. Margaret					Baltimor		4c. County of	
	Funeral Director	213-36-3839	Sex 7. Age	(In yrs. last birthda 59 Yrs.	Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da March	20, 1939	Birthplace (State or Foreign Country) Mary I and
	P &	Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
	the Mary 28e-1 sh notified a	Md. N/A		Baltim	ore					1∕0 Yes 2 □ No
	5 6 8 0	10e. Street and Number 3700 St. Margare	et Street		10f. Zip (	225			10g. Citizen of Wh	
Maryland 21215-0020	urs after des af, or items Examiner, m by Funer	11. Maritel Status  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give X Yeer or Dates:	Ever in U,S. 13	Was Decede If Yes, specif 1 ☐ Yes 2		lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
50	ed within 72 ho tygiene. Wer than "naturn it, the Medical Completed	15. Decedent's E (Specify only highest g		(Giv	edent's Usual e kind of work	done o	during most of work	ing	16b. Kind of Busi	ness/industry
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Vital Records,	aw requir							24a. Was perfo	an eutopsy med?	24b. Were eutopsy tindings available prior to completion of cause of death?
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<u>=</u>	Physician: The I this certificate hural director, page	25. Was case reterred to medical examiner?	Hospital:			Oth	26. Place of Deet			
on of	£ 5 m	1 Yes 2 No  27. Menner of Death  Netural 5 Panding investigation	28e. Date of Injur (Month, Dey	y 28b. Time		c. Injur	4 LI Nursing Ho	-	dence 6 Other	
Division	To the Hospital or Attending Prother 24 hours after death.  To the Funeral Director. After completely filled in by the funeral completely filled in by the funeral medical Certification:	2 Accident investigation 3 Suicide 6 Could not determined	DO Dian at lain	ry - At home, tarm, s . (Specify)				28f. Location (: City or To	Street and Number vn, Stete)	or Rural Route Number,
	within 24 hours at To the Funeral D completely filled i		hysician: To the best o miner: On the basis of and manner sta	examination end/or						
	within To th Comp	29b. Signature end title of certifier	- 1	7-	29c.	Licens	D390	41 9	29d. Date signed of	Month, Day, Year) Strages
	10	30. Name and address of person who	completed cause of de	eath (Item 23a) (Type	a, Print)	tav	bor Ho	spita	1 con	21225
	State Registrar	31. Dete filed (Month, Day, Year) SFP 2 2 199	32. Registre	r's Signeture	Spor	Ks)	/			



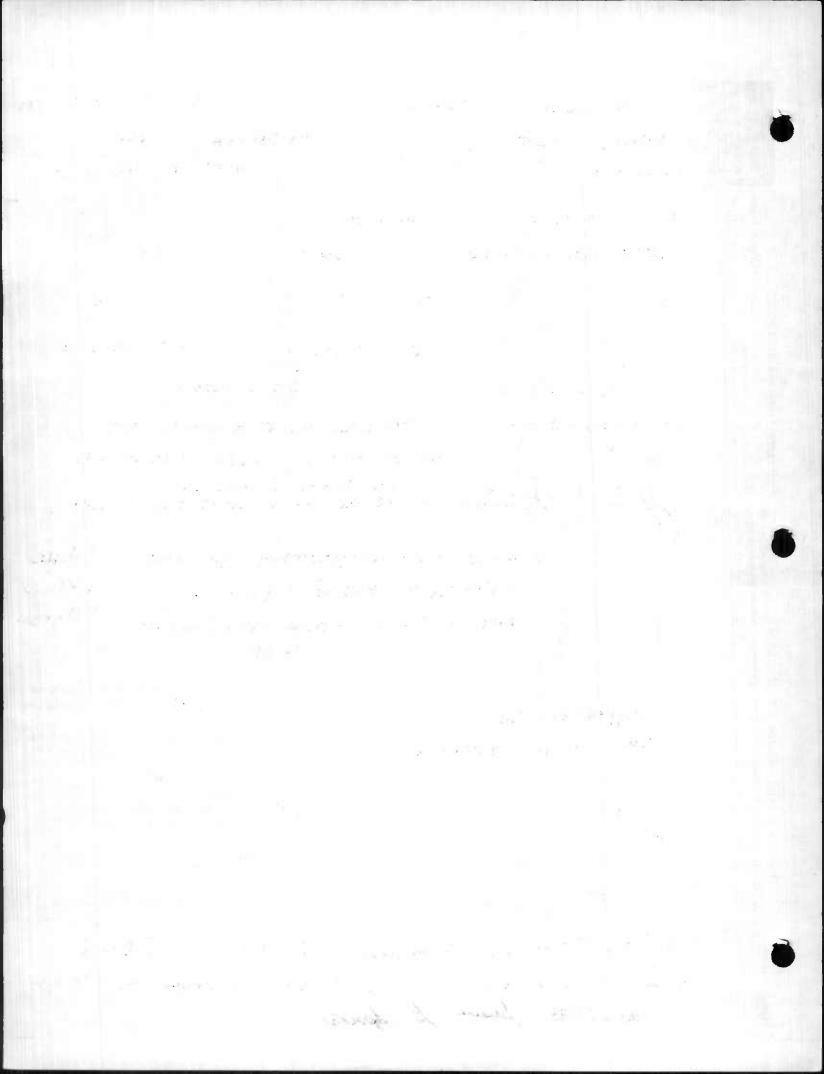
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** 9 6:00 BW WILLIAM WATSO · /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner BETHESDA MANCK CARE If Under 24 Hrs. 5. Sociei Security Number 8. Dete of Birth O 1-01-1917 If Under 1 Year Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** Days 18 M 2□ F Months Hours Min. Yrs. 81 Director 199-09-7914 Pennsylvania Usual Residence of Decedent the Maryland parmit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or itema 23a or 28a-f show any highly or other treumatic event, the Modical Expansion must be notified at another. 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits MYes 2 No Berkeley Director Martinsburg 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1404 Pleasant Court Drive 25401 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1,C,Yes 2 □ No If Yes, Give Yeer or Dates: 1942-45 14. Raca - American Indien, Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Merital Stetus Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: þ 3XIWidowed 4 ☐ Divorcad white Completed Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) Coilege (1-4or 5+) U.S. Post Office driver instructor 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stephen Watso, Sr. Mary Glozeroski 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Carol Kantner - daughter 200. Plece of Disposition (Name of camefery, crematory or other place)

20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burlei 2 ☑ Cremetion 3 ☐ Removel from Stete Rosedale Crematory 9-23-98 Martinsburg, WV 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility
Rosedale Funeral Chapel, Inc. 21. Signature of Fufferal Service License Puf1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, mock, or heart feiture. List only one cause on each line. 25401 Approximete Intervel Between Onset end Deeth **Physician** Immediete Ceuse (Finei disease or condition resulting In deeth) /Medical CARRIORESPIRATORY Examiner Due to (or es e consequence of): Examiner CONGESTIVE MEKRA The law requires that the death certificate be axecuted Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760, CHROVIC OBSTRUCTUR WNG Physician/Medical Due to (or as a consequence of): 980 signed by the a 23b. Did tobecco use contribute to the cause of deeth? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 15 ¥68 2□ No 3 Probably 4 Unknown Division of Vital Records, ģ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? been si Completed 24e. Wes en eutopsy performed? After this certificate has funeral director, page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificalelely filled in by the funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA Certification: To 28c. Injury et Work? 28d. Describe how Injury occurred 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 5 Pending investigation 1 Naturel 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted.

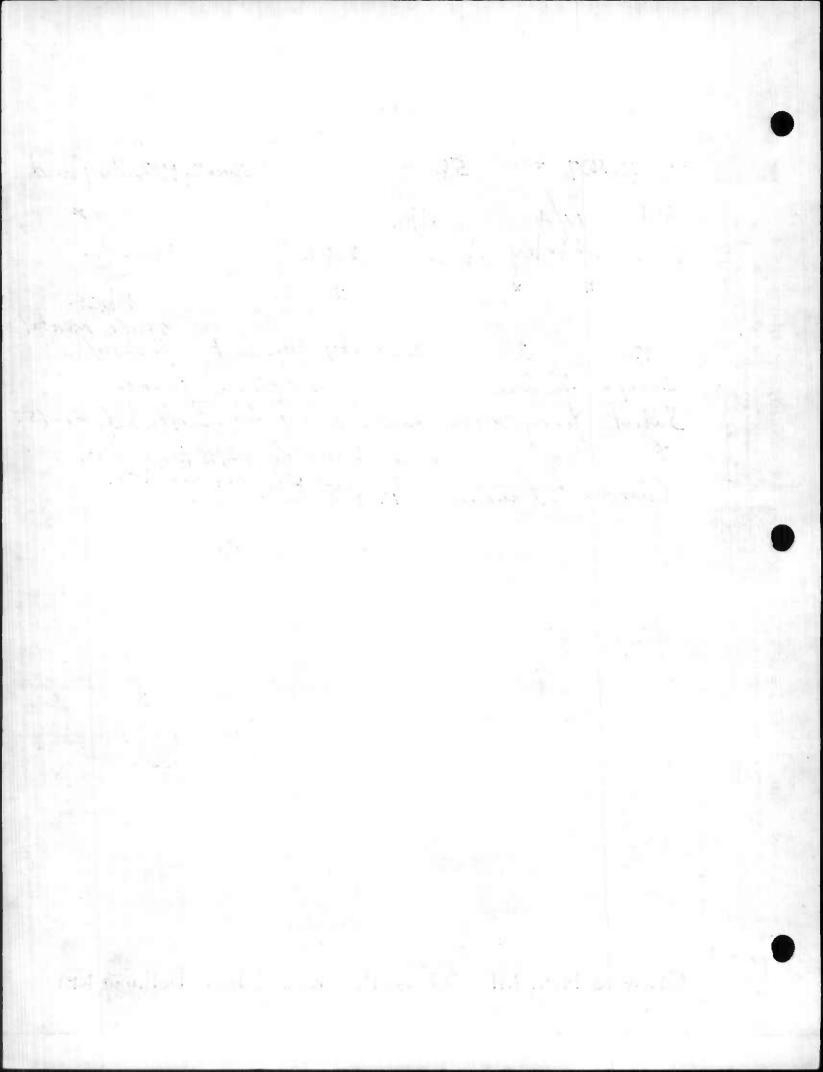
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier edical within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end title of cartifier 116197 - Attening 30. Nerse end eddress of person who completed cause of deeth (Item 23e) (Type, Print) mo -932 Langon - 5 WORLD PO, LANGON. 20706 MUNDOS C. LAGI 32. Registrer's Signature 31. Date filed (Month, Day, Yeer) State SEP 2 2 1998 Sporks Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month. **Physician** 18 pm ames /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of largland led. none HMORE Age (In yrs. last birthday) If Under 1 Year 5. Social Sacurity Number 6. Sex **Funeral** -38-363 219 - 38-363' Usual Rasidance of Decedant 18€M 2□ F 6 Director 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23s or 28s-f show must be notified at 1€ Yas 2 No Director 10f. Zip Code 10g. Citizen of What Couptry? 10e. Street and Number 0 4 215 Funeral death . 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, Whita, etc. 11. Marital Slatus filed within 72 hours after 1 MYes 2 No If Yes, Giva Year or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 naturel', or 1 ☐ Yes 2 No Specity: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during tifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Mother's Nama (First, Middle, ) 17. Father's Nama (First, Middla, Last) pamit. Pegas 1 and 2 should be filt. Department of Heelth and Mentel Hy Important: If Item 27 is marked oth any Injury or other treumatic event DREs. Be Jorda 050 91119 Oles 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nu , Zip Code) 20c. Location - City or Town, State 20b. Place of 20a. Mathod of Disposition 1+ ☐ Burial 2 ☐ Cramation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) al from State 3 □R( 22. Name and Address of Facility 21. Signature of Funaral Sarvice Licepset LVICE 1701 au Mc woh Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause of each line. death. Do not enter the mode of dying, such **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Examiner attending physician end I for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) P.O. I Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 3 Probably Unknown 2 1 ☐ Yes 2 ☐ No been signed t should be dete Records. þ 24b. Were autopsy findings available prior to Be Completed 24a. Was an autopsy completion of cause of death? 2 No 1 Yas 2 No 1 Yas Division of Vital or Attending Physician: 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Aftar this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 5 Pending invastigation 1 Natural NIA 1 Yes death. 2 Accidant NA Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stata) n 24 hours after d 4 - Homicide NI Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifian To the Hosp within 24 hos To the Fune completely fi 29b. Signature and tribled certifier 29c. License number 29d. Data signed (Month, Day, Year) 9 10341 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD Greene Street Huh South

State Registrar 32. Registrar's Signature



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 2. Date of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) Dey Month 1/1999 4c. County of Death EDTEMPER 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number) If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Sociel Security Number Min Hours Months Devs 1 M 2 X F Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Baltemore 1 Yes 2 No Makyland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, 11. Marital Status Black, White, etc. 1 Never Merried 2 Married specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 124RS 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Edgewood Date . 20a. Method of Disposition 20b. Ptace of Disposition (Neme) of cometery, cremetory or other place 20c. Location - City or Town, Stete 1 Buriel 2 Cremetlon 3 Removal from Stete 4 □ Donetion 5 □ Other (Specify) 22. Name end Address of Facility C 21. Signature of Furieral Service Licenses Harterd 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart failure. List only one cause on each line. Melmoma Immediate Ceuse (Final ASTATIC 15 months disease or condition resulting in deeth) Due to (or as e consequence of): Due to (or as e consequence of): Due to (or es e consequence of):

**Physician** /Medical Examiner

The law requires that the death certificate be executed

been si

has a 2 page

funeral director,

filled In by

completely

within 24 hours after death.

To the Funeral Director: After this cartificate

or Attending Physician:

Division of Vital Records, P.O.

**Physician** 

/Medical

Examiner

10e State

Director

Funeral

by

Completed

**Funeral** 

Director

pamit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other treumatic event, The Medical Experime man be notified at any injury or other treumatic event, The Medical Experime man be notified at

Baltimore, Maryland 21215-0020

phyllis

in and Mental Hygiene. 7 is marked other than "natural", or frems 23a or 28a-f show treumstic event, the Medical Examinet must be notified at

Physician/Medical Examiner attending physician and for use as the burial-tran Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Lest ed by the a signed by the

þ

Completed

Be

Certification: To

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Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No

24e. Was en eutopsy performed?

24b. Were autopsy findings eveltable prior to completion of ceuse of death?

1 Yes 2 No

26. Ptece of Deeth (Che	ck only one)

1 Yes 2 No

l	examiner?	U IIIOUICE
l	1 ☐ Yes 258 No	

27. Manner of Death 5 Pending 2 Accident investigation

6 Could not be determined

28a. Date of Injury (Month, Dey Year)

mo

28b. Time of Injury

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 TYes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hespice 28d. Describe how Injury occurred

281. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Naturel

3 Suicide

4 ☐ Homicide

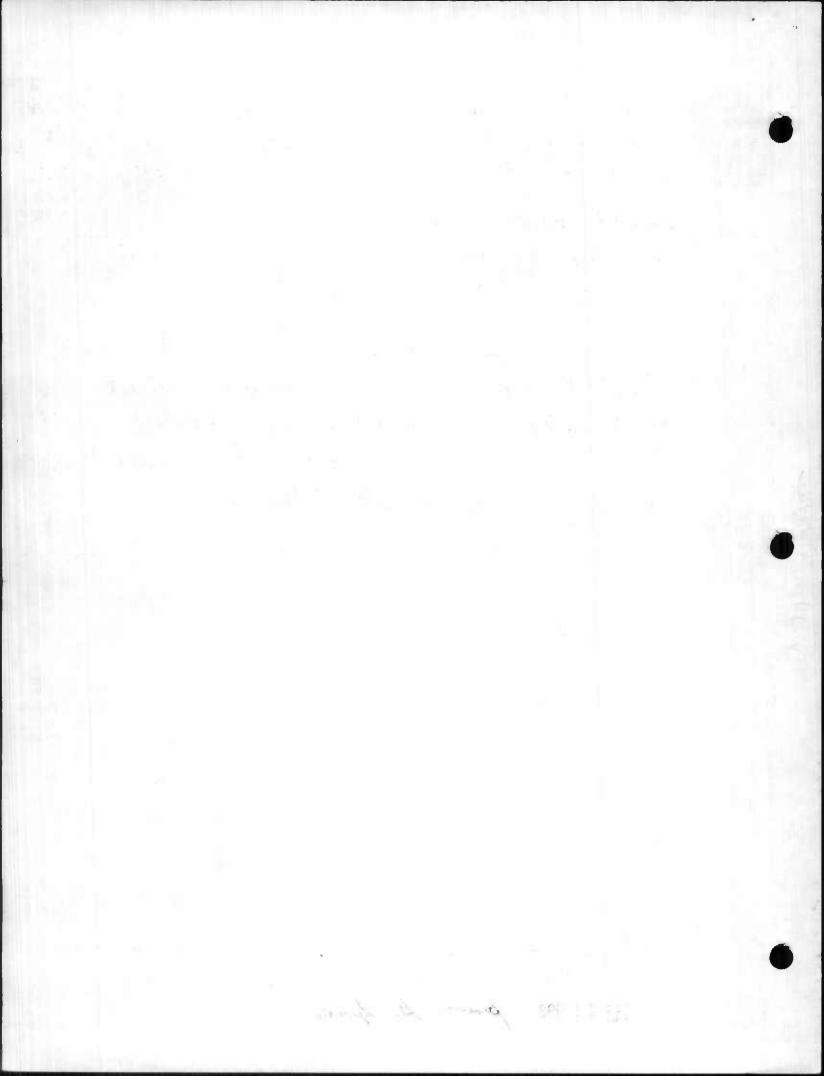
15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier Anthony 29c. License number V25205 29d. Date signed (Month, Dey, Yeer)

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

N. Charles St. GBMC Balto Md ZIZOX 6701

State Registrar 32. Registrar's Signeture



## **Please**

		S	State o	f Mary			tment of hificate of		d Me		jiene 🖫 eg. No.	8	28944
ecedent's Name	(First, Middl	le, Last)			196				2.	Date of Dea			3. Time of Death
Judith	Ann A	lbrig	ht						Se	Month	er 10,	1998	9:00AM
acility Name (If	not institutio	n, give stre	et and nu	m <i>ber)</i>				4b. City, Town, o				ty of Deatl	
loly Cro	ss Hos	spita.	1					Silve	r S	oring	1	Monte	gomery
cial Security Nu	ımber	6. Sex		7. Age (In	yrs. last birt	hday)	If Under 1 Year Months Days	If Under 24 H		Date of Birth (Month, Dey	Veer	9. Birtl	hplace (State or Foreign untry)
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al Residenca of I	Decedent 10b. County			10	- City Town		***						
				10	c. City, Town								10d. Inaide City Limits
MD	Montg	gomer	У		Silve	r SI							1 ☐ Yes 2 ☑ No
Street and Num							10f. Zip Code	20001		1	0g. Citizen of	What Co	untry?
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☐ Never Marrie	-		1 ☐ Yes If Yes, Giv	2 X No			Yes 2⊠ No	Specify:		,/	Speci		
☐ Widowed 4	Divorced		Year or D					-11			Speci	M	hite
	15. Deceder				16a.	Decede (Give ki	nt's Usual Occup ind of work done O NOT use retire	pation during most of w	vorking		16b. Kind of I	Business/I	Industry
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ay Jame								Eleano					
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Donation					Mt. Zi						Masonto		
Signature of Fun	epal Service	Licenson	in	ne	4	Hon	Name and Addresses, Inc. Lver Spr	500 U	nive				
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i. Other signific	ant condition	ons contrib	outing to de	eath but no	t resulting in	the unc	lerlying cause giv	en in Part I.		23b. Did to	bacco uae c	ontribute	to the cause of death?
114	1.0	(0	inci	20						104	es 2□ No	3 🗆 Pr	robably 4 Unknown
100	7									24a. Was a perform		6	Were autopsy findings eveilable prior to completion of cause
											,	(	of death?
										1 □ Y	es 22No	1	1 ☐ Yes 2 ☐ No
Vas case referre	ed to medica	1						26. Piece of D	Death (	Check only or	ne)		

Physician /Medical Examiner

within 24 hours aftar death.

To the Funeral Director: Aftar this cartificate has been signed by the attending physician and complataly filled in by the funeral director, page 2 should be detached for use as the burial-transit

The law requires that the death certificate be axecuted

or Attanding Physician:

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

PV

Completed

To Be

Physician/Medical Examiner

by

Medical Certification: To Be Completed

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Deportment of Health and Mantai Hygiene. Important: if Item 27 is marked other than "natural", or items 22 any injury or other traumatic event.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest

Immediate Cause (Final disease or condition resulting in deeth)

1. Decedent's Name (First, Middle, Las

4a. Facility Name (If not institution, give

Elementary/Secondery (0-12) 17. Father's Neme (First, Middle, Last)

Ray James LaRue 19a. Informent's Name/Relationship (7 Richard Albright

20a. Method of Disposition

5. Social Security Number

10a. State

11. Marital Stetus

10e. Street and Number

Usual Residence of Decedent

Pert il. Other significant conditions	contributing to death	but not resulting i	in the underlying	cause given in Part

. was case referred to medical				26. Plece of I	Death (C	check only one)	
examiner?	Hospital: 1X Inpatient 2	ER/Outpatient	3□ DOA	Other: 4 \( \sum \) Nursing	Home	5 Residence	6 ☐Other (Specify)
Manner of Death	28a. Dete of Injury	28b. Time of	28c.	Injury at	28d	. Describe how inj	ury occurred

scribe how injury occurred 5 Pending Investigation 1 Naturel ionth, Day Year) Work? 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifie

29d. Date signed (Month, Dey, Yeer)

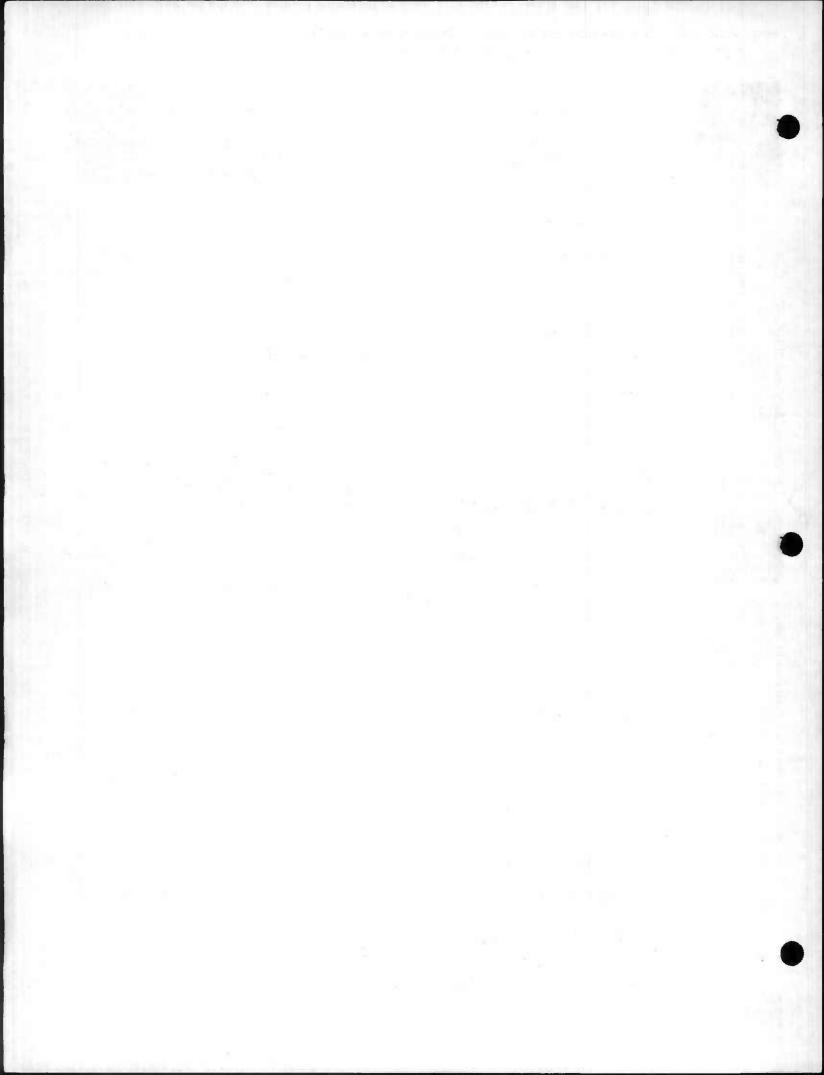
30. Name and ad of death (Item 23e) (Type, Print)

31. Date filed (Month. Day, Year

(Check only one)

Bogistrar's Signature 32

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Dey Year SEPTEMBER 2, 1998 6:20 AM JEANNE J. ALTMAN 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death MONTGOMERY NURSING HOME SILVER SPRING If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Year) Birthplaca (Stete or Foreign Country) 1□M 2₩ F Months Days Hours Yrs. 76 11/29/21 NEW YORK 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XX No SILVER SPRING MONTGOMERY 10f. Zip Code 10g. Citizen of What Country? 11904 RENICK LANE 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Educetion (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC HOMEMAKER 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) HAROLD R. JACKSON JENNETTE PAGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 11904 RENICK LANE SILVER SPRING MARYLAND 20904 LANDY B. ALTMAN / HUSBAND 20b. Piace of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9/9/98 ARLINGTON, VIRGINIA ARLINGTON NATIONAL CEM. 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC 21. Signature of Funeral Service Licensee se, of complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, that only one cause on each line. 11800 NEW HAMPSHIRE AVE SILVER SPRING MD 20904 Approximate Interval Between Onset end Deeth month Due to (or as e consequence of): Due to (or es a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Unknown 1 Yee 2 No 24b. Were eutopsy findings available prior to 24a. Wes en eutopsy performed? completion of cause of death? 1 🗆 Yes No 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

BS esn ed by the a signed by t

**Physician** /Medical

Examiner

Physician/Medical Examiner physician end the burial-transit à Completed page 2 Be 10 Certification:

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Merylend Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show shay injury or other traumatic event, to Medical Exercises to entitle and any injury or other traumatic event, to Medical Exercises to entitle any page.

Baltimore, Maryland 21215-0020

SPRINGBROOK

5. Social Security Number

242-32-5807

10e. Street and Number

20a. Method of Disposition

Immediate Cause (Final

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury

that initiated events resulting in death) Last

1 Yes 2 No

27. Manner of Death 1 Natural

2 Accident

4 Homicide

(Check only one)

3 Sulcide

29a. Certifier

disease or condition resulting in death)

11. Marital Status

10a State

Directo

Funeral

by

Completed

Be

Usuai Residenca of Decedent

has certificate this funeral After

certificete be axecuted P.O. Box 68760. Division of Vital Records, or Attending Physician: r deeth. 24 hours after deel Funeral Director: 3 Hospital completely

> State Registrar

Medical

31. Date filed (Month, Dey, Year)

29b. Signeture and title of certifie

ar

SEP 08 1998

32. Registrar's Signature

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

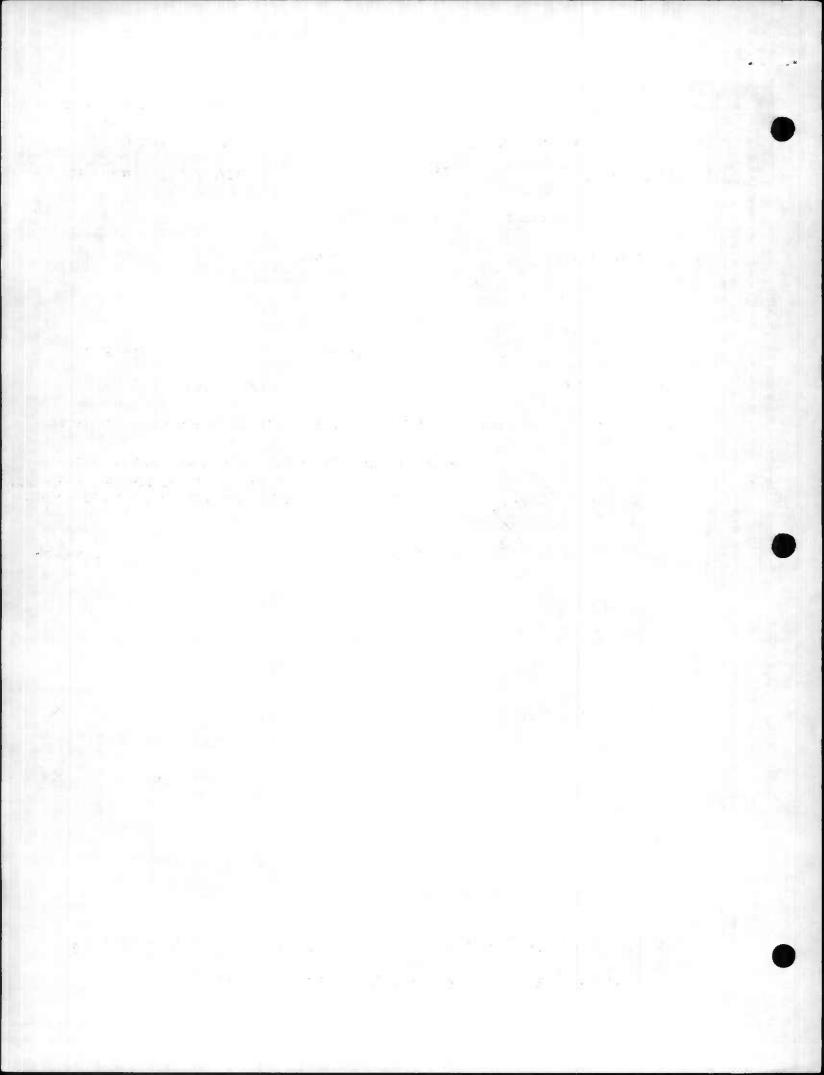
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date end pleca, and due to the cause(s) and manner steted.

29c. License number

29d. Dete signed (Month, Day, Year)

**DHMH 16 Rev 6/95** 

To the F within 2



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				(	Certifica	ite of	Death			Reg. No.	4	.0740
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n al	Arjuna O. Abayom	i-Cole							August		98	9:40 AM
er er	4a. Fecility Nama (If not Institution, give	re street and nu	m <i>ber)</i>				4b. City, To	own, or L	ocation of Deeth	4c. County	of Death	
	Ft. Washington H	ospital					Ft. W	ashi	ngton	Princ	e Ge	orges
			7. Aga (In yrs.	last birth	day) If Und	er 1 Yeer	If Undar	24 Hrs.				
	013-26-7034	Sax NDM 2□F	76		rs. Month	Days	Hours	Min.	Nov. 2	y, Year)		placa (Stata or Foreign ntry) rra Leone
	Usual Residence of Decedant		,,,						1100. 2	,1741	DIE.	LIA Leone
	10e. Steta 10b. County		10c. Cit	ly, Town	or Location							10d. Insida City Limits
5	Maryland Drings C		TP.	II.	1. 1							1 X Yas 2 □ No
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5										Tog. Citizen of	what Cou	ntry r
ō	2000 Thistlewood					0744				Unite		
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5	3 ☐ Widowed 4 ☐ Divorced	Yeer or D	etas:			-X-110	ороспу.			Specif	y: Bla	ack
5	15. Decedant's E (Specify only highast gra			16a. E	Decedent's Us	ual Occup	oation	et of work	kina	16b. Kind of B	ualness/In	ndustry
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9	John Abayomi-Col	е					Do	rcas	Black			
-	19e. Informant's Nama/Raiationship (	Type, Print)		19b. I	Malling Addra	ss (Street	and Numb	er or Rui	rai Routa Numbe	er. City or Town	Stata. Zii	n Code)
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	rasulting in daath)	0.	Dua to (c	or as a co	nsaquanca o	f):						
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3	rasulting In death) Lest		540,10 (5		, looqua, loa oi	,						
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3												
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2											of	daath?
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	3 ☐ Sulcida 6 ☐ Could not b 4 ☐ Homlclda daterminad	28a. Placa	of Injury - At heng, atc. (Specif		n, street, facto	ory, office			28f. Location (5 City or Tox	Straat and Numi m, Stata)	ber or Run	ei Route Number,
	29a. Cartifiar 1 Certifying Ph (Check only one)	niner: On tha ba	best of my kno asis of axamina nar stated.	wladga, d	daath occurra or Investigatio	d at the ti	ma, data ar opinion, dae	nd placa, oth occur	and dua to that red at tha time,	causa(s) and madate end plece,	annar as s end dua t	stated. o the ceusa(s)
	29b. Signeture end titla of minimum	/			2	9c. Licens	se number			29d. Date signa	d (Month,	Day, Yaar)
	1/1/	1.		_		D41	182			Septemb	er 1.	1998

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the ettending physician and Completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit Division of Vital Records, P.O. Box 68760,

Physician /Medica Examine

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mentel Hyglene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, if a Medical Examiner must be notified at once.

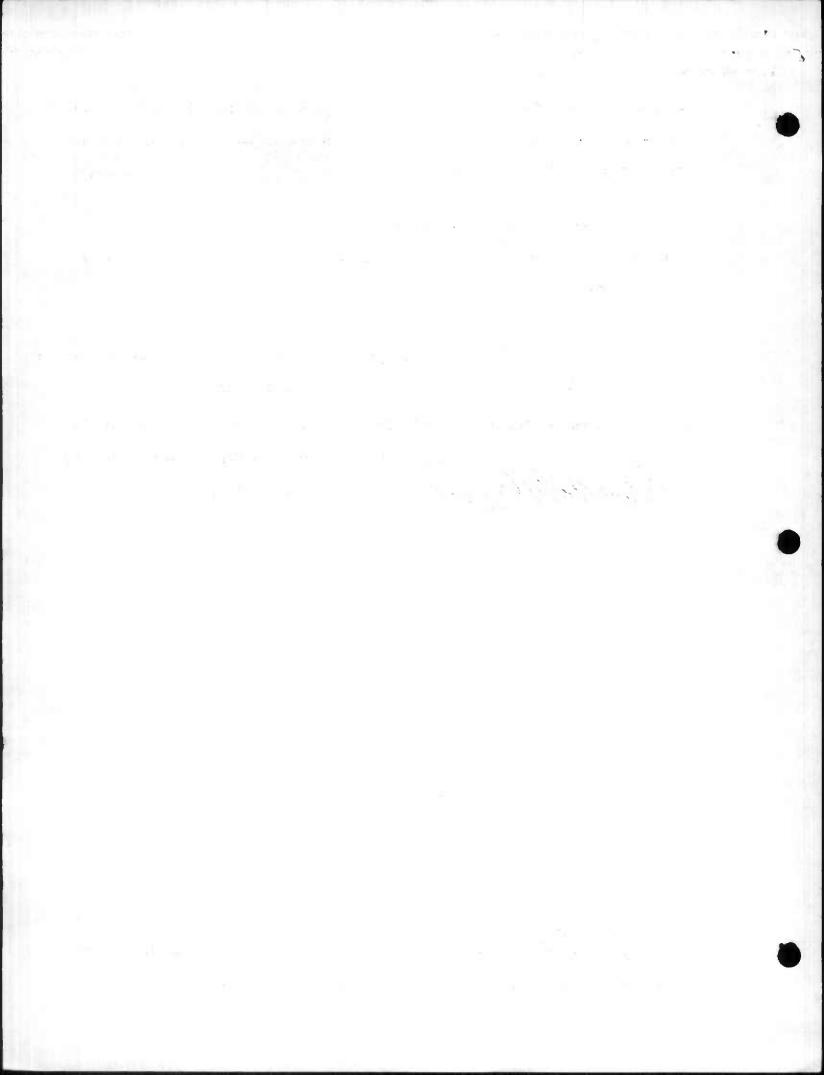
Physician /Medical Examiner

Baltimore, Maryland 21215-0020

State Registrar 31. Date filed (Month, Day, Year) **SEP 0 8 1998** 

Felton Anderson, M.D., 8909 Old Branch Avenue, Clinton, Maryland 20735 32. Registrar's Signeture

30. Name end extress of person who completed cause of deeth (Item 23a) (Type, Print)

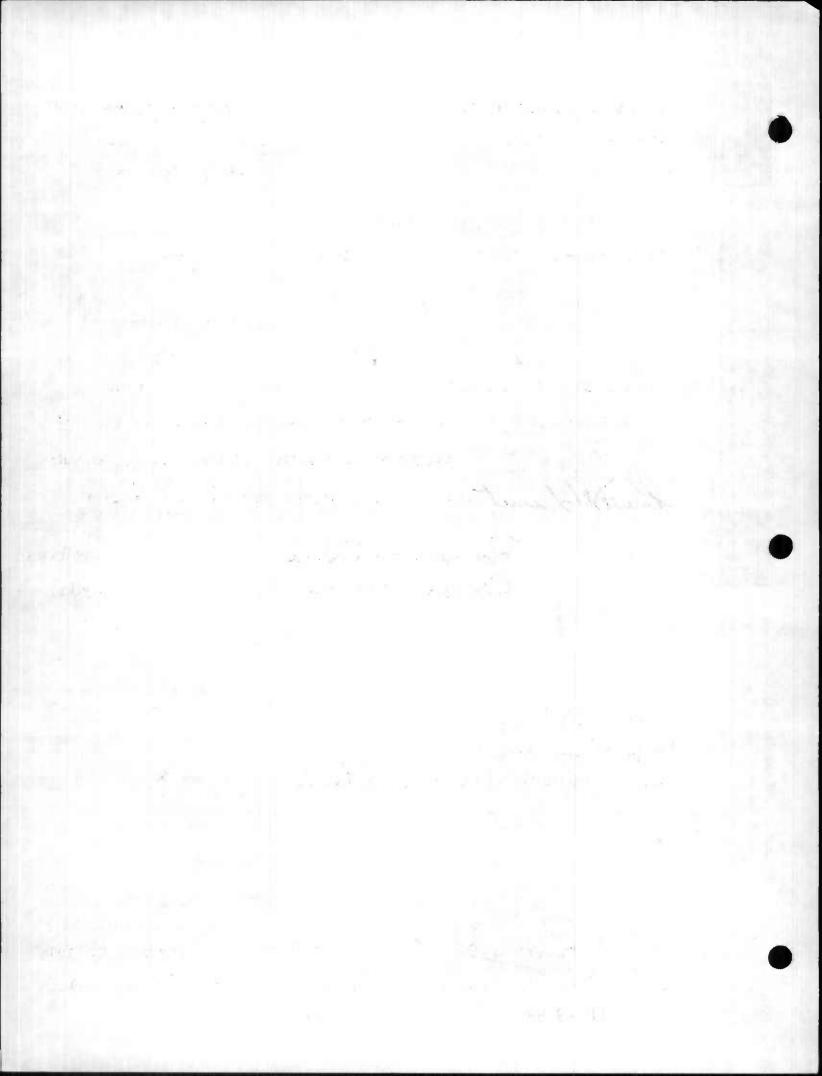


		1 December Name /First Addute 1 a	n#1	Certifica	ate of Death	-	Reg. No/	20041
Physic /Medi	cal	Decedant's Name (First, Middla, La     Sarah Elizabet)     4a. Fecility Nama (If not institution, give				2. Data of Dec Month Septemb	Day 19	
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nd Mental marked o umatic eve	To Be C	17. Fathar's Nama (First, Middla, Last, Daniel L. Swart  19a. Informant's Name/Ralationship (	zentruber		18. Mothar's I	Nama (First, Middla,  Ora L. Lic	hty	
t of Health If Item 27 or other tr		Harriett M. Moc  20a. Mathod of Disposition  1 M Burial 2 □ Cramation 3 □  4 □ Donation 5 □ Other (Specification of the properties)	n/Sister		DeWitt Road Vama of or other p/aca)		d, Maryla 20c. Location - Ci	and 21550 ity or Town, Stata
Departmen Important: any injury once.		21. Signeture of Funeral Sa vice Loan  23a. Part1. Enter the diseasa, or com- shock, or haart failure. List only	see	22. Nama Stewa	and Addrass of Facility	lome		Maryland
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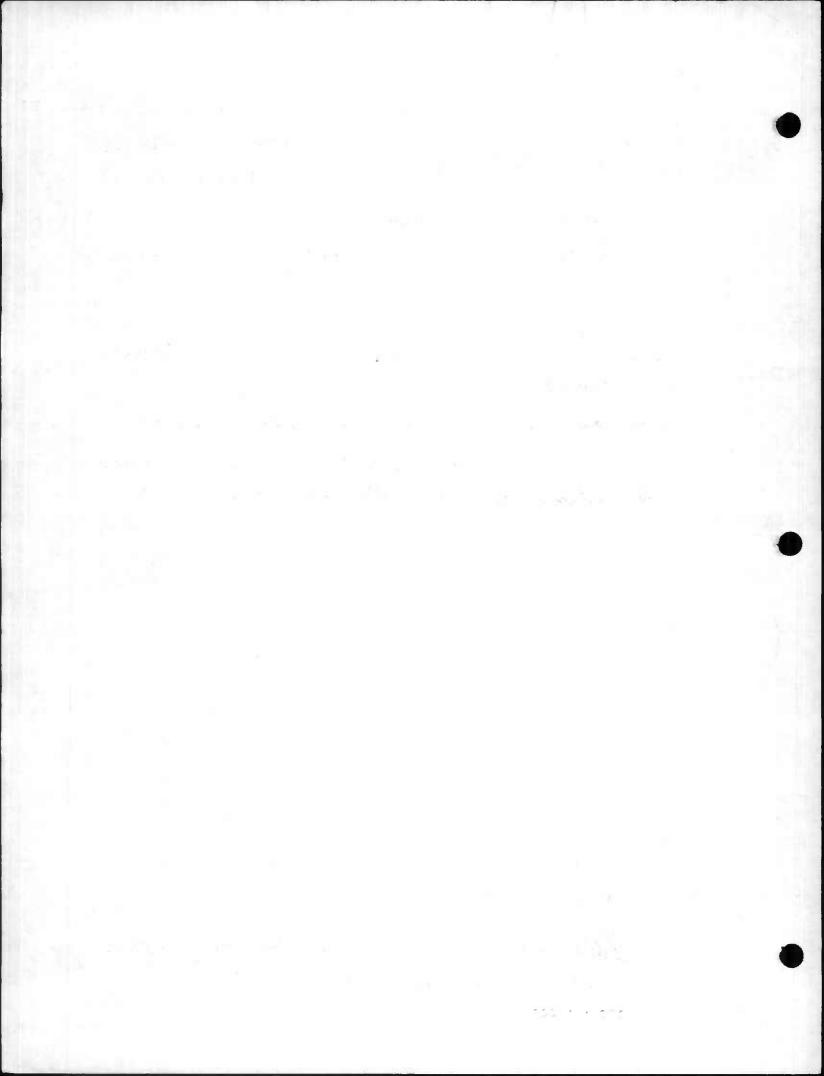
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State of Maryland / Department of Health and Mental Hygiene

						(	Certi	ficate of	Death			Reg. No.			
· .		Decedent's Neme (First, Middle, Last)									2. Dete of Deeth Month Dey Ye			3. Time of Death	
Physici /Medic		MAURICE S. BROOKHART, JR.										MBER 6		2340	
Examin										own, or L	ocation of Deeth 4c. County of I		ty of Death		
		SACRED HEART HOSPITAL								ERLA		AL	Y		
and 21215-0020 be filed within 72 hours efter death with the Maryland tel Hygiene. d other than 'natural', or items 23a or 28a-f show event, the Medical Evanture must be noted at		5. Social Security Number 6. Sex 7. Age (In yrs. last birth				N	If Under 1 Year Months Devs	If Under Hours	r 24 Hrs. Min.	(Month D	Dev Year)		Birthplece (State or Foreig Country)		
		213-18-2629   123M 2D F   83 Yrs.									MAY 12	, 1915	MARY	LAND	
	9	Usual Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location											10d, Inside City Limits		
	2												1 X Yes 2 □ No		
	Direct	10e, Street end Number 10f. Zip Code										10- 04	f What Country?		
				OM CUDE	EW.				21550 seedent of Hispanic Origin? (Specify Yes or No			10g. Citizen of Whet Country?			
	erai		PENNINGTON STREET			ives in 11 C	12 Ma					USA			
	un-	11. Maritel Stetus	rried 2 Marrie	Armed F	Armed Forces?			If Yes, specify Cuben, Mexicen, Puerto			o Rican, etc.)				
It, or	by F		4 Divorced	If Yes, G	WW II	1 🗆	1 ☐ Yes 2 No Specify:				Spec	Specify: WHITE			
21215-0020 d within 72 hours ef gjene. or then "neturel", or or the Wedicel Exem	Pa		15. Decedent's		resting 16s Doordon			nt's Usuel Occupetion				16b. Kind of Business/Industry			
	plet	(Specification)	ecify only highest	grade completed	-	(9	Give kin life. DO	kind of work done during most of the DO NOT use retired)			king				
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should be and Mentel or marked o	ToB	MAURICE SOLOMON BROOKHART SARAH DURHA										JRHAM			
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E = 0 +		MAURICE	S. BROO	KHART I	II -	SON 9	44 (	OLD ORC	HARD	ROAL	) CHAI	PEL HIL	, NC	27514	
of Hear		20a. Method of Dis	•			20b. Piece of D	Dispositi cremet	ion (Neme of tory or other ple	ce)		Date	20c. Location	- City or T	own, Stete	
Baltimo Baltimo Bernit. Page Department Page Negrotant Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important Important I			2 ☐ Cremetion 3 5 ☐ Other (Spe		n State			EMORIAL	,	ENS	9/10/98	OAKLAN	D, MA	RYLAND	
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		M00167 DURST FUNERAL HOME - OAKLAND,												550	
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oxecular and and riel-train		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury c.													
x 68760, sertificate be executed ding physician and se es the buriel-transit	edicai	that initiated events													
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_ · · · · · · · · · · · · · · · · · · ·	Physician											Did tobacco use contribute to the cause of de			
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f Vital Record yaldan: The law requir s certificeta has been s director, page 2 should To Be Completed	Pa											24e. Wes en eutopsy pertormed? 24b. Were eveil			
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DIVISION To the Hospital or Attent within 24 hours efter deal To the Funeral Director: completely filled in by the Medical Certifical		29a. Certifier				my knowledge,									
	pa	(Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.												to the cease(s)	
	2	29b. Signeture end title of certifier 29c. License r								se number 29d. Date sign			ed (Month, Day, Year)		
		twair Way							31875			SEPTEMBER 8 1998			
15 11	1	30 Neme end add	dress of person w			eeth (Item 23e) (T	ype, Pri	int)			1	110			
13+11H	r	Kobert Welk M.D 902 Seton Drive Cumberland, MD 21502											02		
Sta		31. Dete filed (Mo	onth, Dey, Year)		Registre	r's Signeture	4	1	14						
Registr	ar		2FL - 8	1998	A Property	/	U.	poor	2	,					



Certificate of Death Reg. No.  1. Decedent's Name (First, Middle, Last)  2. Date of Death 3. Time of Death 3. Time of Death											Death	
rley	Α.	A. Broadwater					Month Sept. 02 1998 11:05					
4e. Feclity Neme (If not institution, give street and number)  4b. City, Town, or Lo									of Death			
ox 134		Mosc					Allegally					
3032					Jnder 24 Hrs. ours Min.	8. Dete of Bi (Month, Di Dec.	irth (ay, Year) 9. Birthplece (Sta Country) 9. Birthplece (Sta Country) 9. Birthplece (Sta			r Foreign		
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location										d. inside Ci		
Allega	nv		Moscow							Y Yes 2 N		
Number	2	10f. Zip Co	ode			10g. Citizen of What Country?						
. Box 134		21521						United	Sta	tes		
us Married 2 Narried ed 4 Divorced	Armed Forces 1 Yes 2 If Yes, Give	1 Yes 2 No			Decedent of Hispanic Origin? (Specify Yes or N , specify Cuben, Mexican, Puerto Rican, etc.) 'es 2 🔯 No <i>Specify:</i>				No- 14. Race - American Indian, Black, White, etc.  Specify: White			
15. Decedent's Ed Specify only highest gra-	ucation		16a. Decede	ecedent's Usual Occupation live kind of work done during most of workin fe. DO NOT use retired)			king	16b. Kind of B	16b. Kind of Business/Industry			
ntary/Secondary (0-12) College (1-4or 5			COO	_					taurant			
17. Father's Name (First, Middle, Last)  William Mongold  Nina Dv								e (First, Middle, Maiden Surname)				
s Neme/Relationship (7	• • • • • • • • • • • • • • • • • • • •						ural Route Number, City or Town, State, Zip Code)					
nd Broadwa	ater	12402				4,Mos	COW Md	. 2152				
Disposition 2 Cremation 3 con 5 Other (Specify	Removel from Stat	20b. Placa of Disposition (Neme of cemelery, crematory or other pleca)  Bloomington Cem 9/6						20c. Location - City or Town, Stete Bloomington, Md				
21. Signeture of Funeral Service Licensee  22. Name and Address of Facility  Boal Funeral Home 111 Church St												
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, interval Between Onset end Death  Immediate Cause (Final disease or condition resulting in deeth)  a. RESPIRATURE FAILURE												
	Due to (or as a consequence of):											
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that inflitted events resulting in death) Last  b. METASTATIC LUNG- CAWCEN  Due to (or as a consequence of):  C. Due to (or es e consequence of):									VE (6	HOL		
ents th) Last	d	Due to (or	r es e consequ	ence of):								
gnificant conditions co	contributing to death but not resulting in the underlying cause given in Part i.						23b. Did	tobacco use co	ntribute to	the cause o	of death	
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							24a. Was an autopsy performed?  24b. Were autopsy evellable pric completion of death?			ilable prior to pletion of c	0	
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eferred to medical	26. Place of Death (Check only one)											
Peath	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 (2 Residence 6 ☐ Other (Specify)  28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred							)				
5 Pending investigation 6 Could not be	(Month, Dey Year) Injury Work?  Injury Work?  Injury Work?  Injury Work?											
de determined	City o			City or To	tion (Street and Number or Rural Route Number, or Town, State)							
29a. Certifier  (Check only one)  1 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause one)  29b. Signature and title-of cartifier  29c. License number  29d. Date signed (Month Day Year										ated. the cause(s		
end title of cartifier		29c. License number					29d. Date signed (Month, Day, Year)					
ddress of person who o	ompleted cause of	deeth (Itam	23a) (Type P	(Print)	3341	7 (MR	ntemp)	JAMES R	- Mes	V M.D.		
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3	NATION nth, Dey, Year)	NATIONAL (1164) nth, Dey, Year) 32. Regis	NATIONAL (176+WAY nth, Dey, Year) 32. Registrar's Signe	MATIONAL INCHWAY LAUK nth, Dey, Year) 32. Registrar's Signeture	nth, Dey, Year) 32. Registrar's Signeture	nth, Dey, Year) 32. Registrar's Signeture	nth, Dey, Year) 32. Registrar's Signeture	MATISMAL INCHWAY LAVME, MD 21502  nth, Dey, Year)  32. Registrar's Signeture	nth, Dey, Year) 32. Registrar's Signeture	nth, Dey, Year) 32. Registrar's Signeture	nth, Dey, Year) 32. Registrar's Signeture	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Piel Rita Brown August 31, 1998 10:40 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Collingswood Nursing Center Rockville Montgomery If Under 1 Year If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 M 2 X F 84 Director 046-38-6867 October 22, 1913 New York Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show 1 Nas 2 No Director Maryland notifie Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Herns 23s or 299 Hurley Avenue 20850 United States Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🔯 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiens. Elementery/Secondery (0-12) College (1-4or 5+) 0 Homemaker Own Home . Pages 1 and 2 should be flied a ment of Health and Mental Hygier fant: if hem 27 is marked other to jury or other traumatic event, the 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William F.J. Piel Loretto Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1016619e. Informent's Neme/Relationship (Type, Print) 200 Park Avenue, Suite 2300, New York, New York Hobson Brown, Jr./Son 20b. Place of Disposition (Name of cametery, cremetory or other place) September 9, 1998 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removet from Stete Department of Department of Important: If any Injury or page. 4 Donetion 5 Other (Specify) Gate of Heaven Cemetery Hawthorne, New York 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, 21 Signature of Funeral Sety ceul ices M00846 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Renal Failure 1 Year **Examiner** Due to (or es e consequence of): Examine b. Hypertension hysician end the burial-transit The lew requires that the deeth certificate be axecuted Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): physician Physician/Medical Due to (or es a consequence of): 98 nse i signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, py 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? page 2 should Completed 1 ☐ Yes 2 No 1 Yes 2 No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Yes 2 No 24 hours after death.

Funeral Director: A 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 2 4 | Homicide Hospital Medical 29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner steted. (Check only one) To the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) . Shakin D27830 September 1, 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramleth T. Shakir, M.D. 9019 Shady Grove Court, Gaithersburg, Maryland 20877

State Registrar

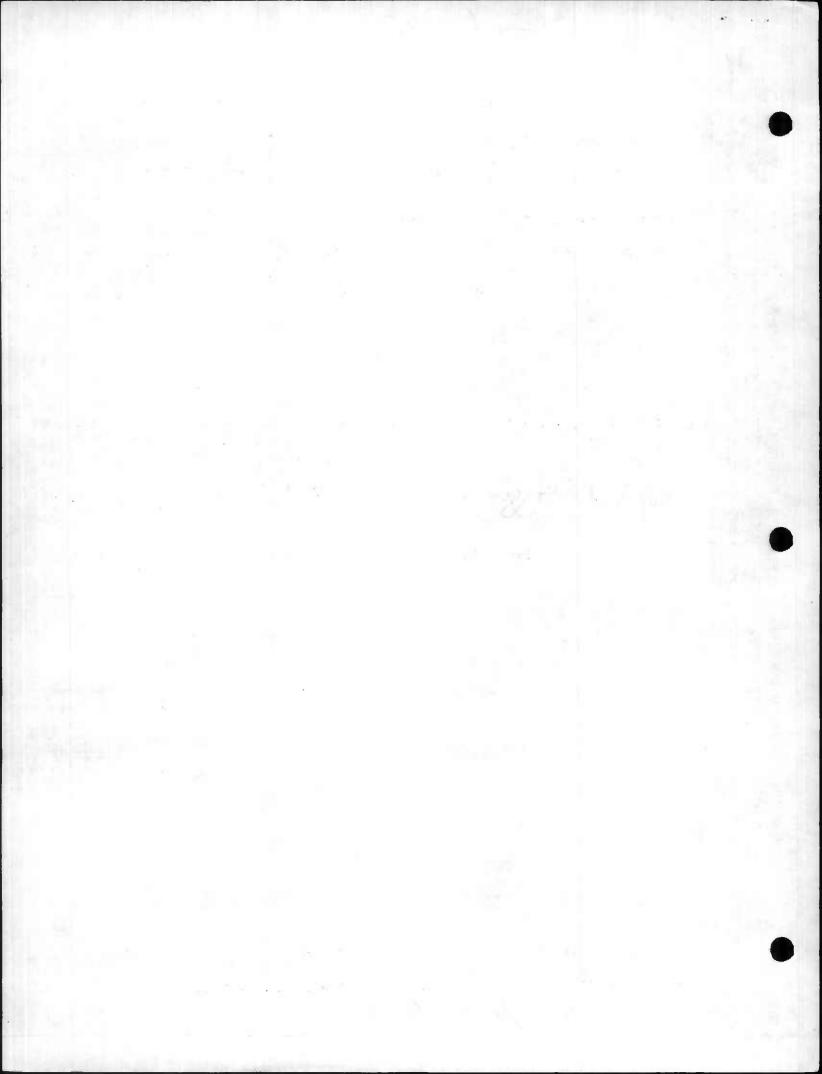
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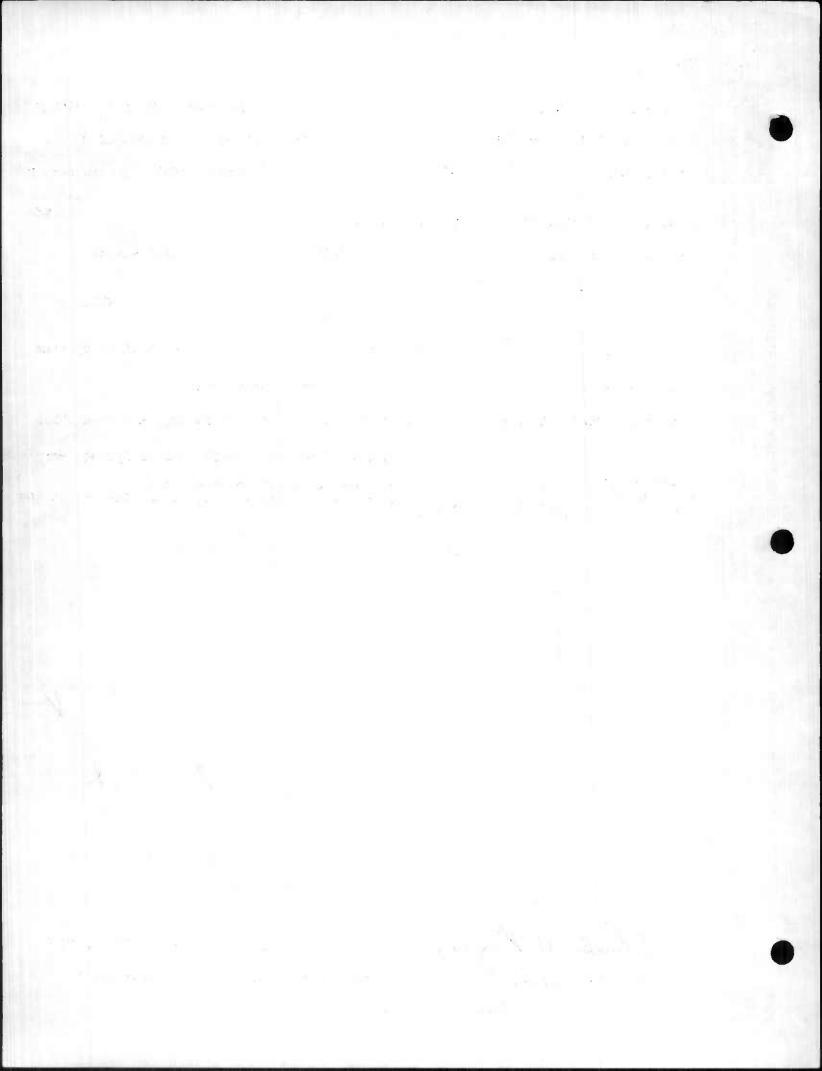
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day **Physician** September 5, 1998 3:05 PM Marion Ballard /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth **Examiner** 1466 Heather Ridge Court Frederick Frederick 8. Data of Birth (Month, Day, Year) Sept. 5, 1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 1 F 81 Yrs. 367-14-9746 1917 Director New Hampshire Usual Rasidance of Decedant 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2K No Director Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 1466 Heather Ridge Court USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U.S. Armad Forcas? Race - American Indian, Black, Whita, etc. 1 ☐ Yes 2 ☒ No If Yas, Giva 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White ₹ A 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) Collega (1-4or 5+) 12 Waitress Food Service permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
important: if Item 27 is merked other
any Injury or other trauments. 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumeme) 8 Everett Ballard 2 Gladys French 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Tom C. Ballard 13027 Bellevue Street, Beltsville, MD (son) 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/9/98 4 ☐ Donation 5 ☐ Othar (Specify) Cedar Hill Cemetery Suitland, MD 22. Nama and Addrass of Eacility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West 21. Signatura of Funarai Sarvice Licensee slemi 20901 Silver Spring, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final ancreatic disaase or condition resulting in deeth) Examiner Examiner attending physician and for use as the burial-transit be executed Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated evants rasulting In daath) Last Dua to (or as e consequence of Box 68760. Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 3 Probably 4 2 Unknown 1 | Yes 2 | No by 24b. Wera autopsy findings available prior to completion of cause of death? should I Completed 24a. Was an autopsy performed? 988 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate I or Attending Physician: after death. Director: After this certific 25. Was casa ralarred to medical axaminar? Be 26. Place of Deeth (Check only one) axaminar/ 12 Yes 2 No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 10 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. tnjury et Work? 28d. Describe how injury occurred Medicai Certification: 1 Netural
2 Accident 5 Pending 1 Yes 2 No invastigation 6 Could not be datarmined 3 Suiclda 281. Location (Street and Number or Rural Routa Number, City or Town, State) Place of Injury - At home, larm, street, lactory, office building, atc. (Specify) 4 Homicide • Funeral Di Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar

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29b. Signature and title of certifier,

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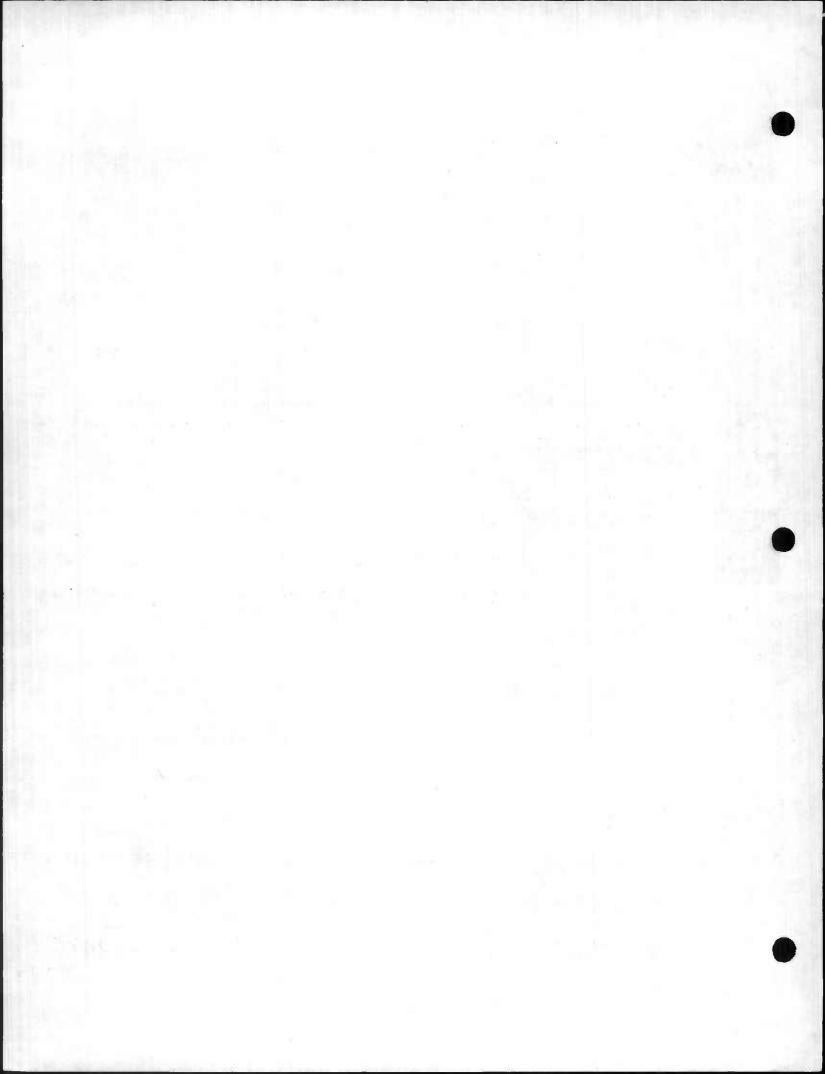
Nama and addrass of person who completed cause of death (Item 23a) (Type, Print).

McCrew Tr., MD 1080 W. Patrice St Frederick in 121703 Year) 32. Degistrar's Signatura 1998

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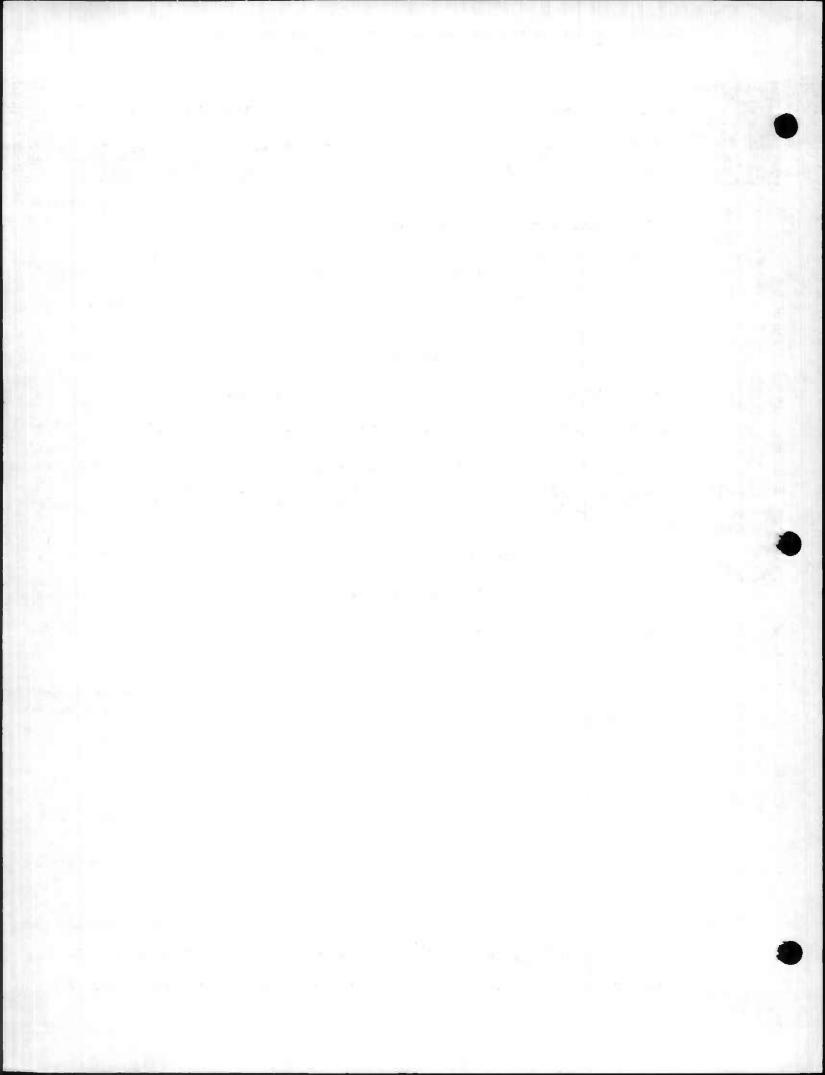
29d. Date signed (Month, Day, Year)

September 8,1998



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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Nema (First, Middla, Last) 2. Deta of Death 3. Time of Death Month Dev **Physician** Charles King Be1tz September 1, 1998 13:45 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5712 Glenwood Road Bethesda Montgomery If Under 1 Yaer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** Days Hours Months 1 M 2 □ F 190-10-5976 90 Director February 20, 1908 Pennsylvania Usual Residence of Decedent death with the Meryland 10a. Stata 10b. County 10c. City. Town or Location ehow 10d. Inside City Limits mast be notified at Maryland 1 ☐ Yas 2 No Director Montgomery Bethesda 10e. Street and Number 10f. Zin Coda 10g. Citizen of What Country? 5712 Glenwood Road 20817 United States Funeral Neme ? 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yes, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Race - Amarican Indian, Bleck, White, etc. 11. Merital Status r than "naturel", or item the Medical Example: filed within 72 hours efter 1 Never Married 2 Married 21215-0020 1 ☐ Yas 2 ☒ No Specity: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry intel Hygiene. ed other than c event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Communications 12 Baitimore, Maryland permit. Pages 1 and 2 abouid be flist Department of Heelth and Mental Hy important: If Item 27 is marked other any Injury or other treumatic event. 17. Fether's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Surneme) Be Samuel Beltz Mary Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Sarah B. Murray/Daughter 1706 Mark Lane, Rockville, Maryland 20852 20b. Place of Disposition (Nama of cametery, crematory or other place) September 6, 1998 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 M Burial 2 ☐ Cremation 3 ☐ Removel from Stata Shrewsbury Lutheran Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) Shrewsbury, Pennsylvania 22. Nama and Addrass of Facility Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, 1 7557 Wisconsin Avenue, Bethesda, Maryland 20814—3501 21s Signature of Funeral Service Licens M00846 Der 23a. Pert K Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one carding on each line. Approximata Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Cardiovascular Disease Examiner Due to (or as a consequence of): Examine Hypertension The law requires that the death certificate be executed the buriei-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Dua to (or as a consequence of) physician c Cardiac Valvular Disease Physician/Medical Due to (or as a consequence of): 8 Prostate Cancer 907 ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings aveitable prior to completion of cause of death? page 2 should Completed 24a. Was en eutopsy Deen performed? certificate has 1 ☐ Yas 2 No 1 □ Yas 2 □ No Be 25. Was case referred to medical 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 X Yes 2 No this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Naturat 1 Yas 2 No

Box 68760. P.O. Records, Division of Vitai or Attending Physicien: luneral After the 6

efter death. lilled in Hospital 24 hours

2 Accident 3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

(Check only one)

To the Hosp within 24 hor To the Fune completely fi 25

29b. Signature and titla of certifier Moert K Ree mi) D31282

1K Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year)

September 3, 1998

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

30. Name and addrass of person who completed causa of death (ttern 23a) (Type, Print)

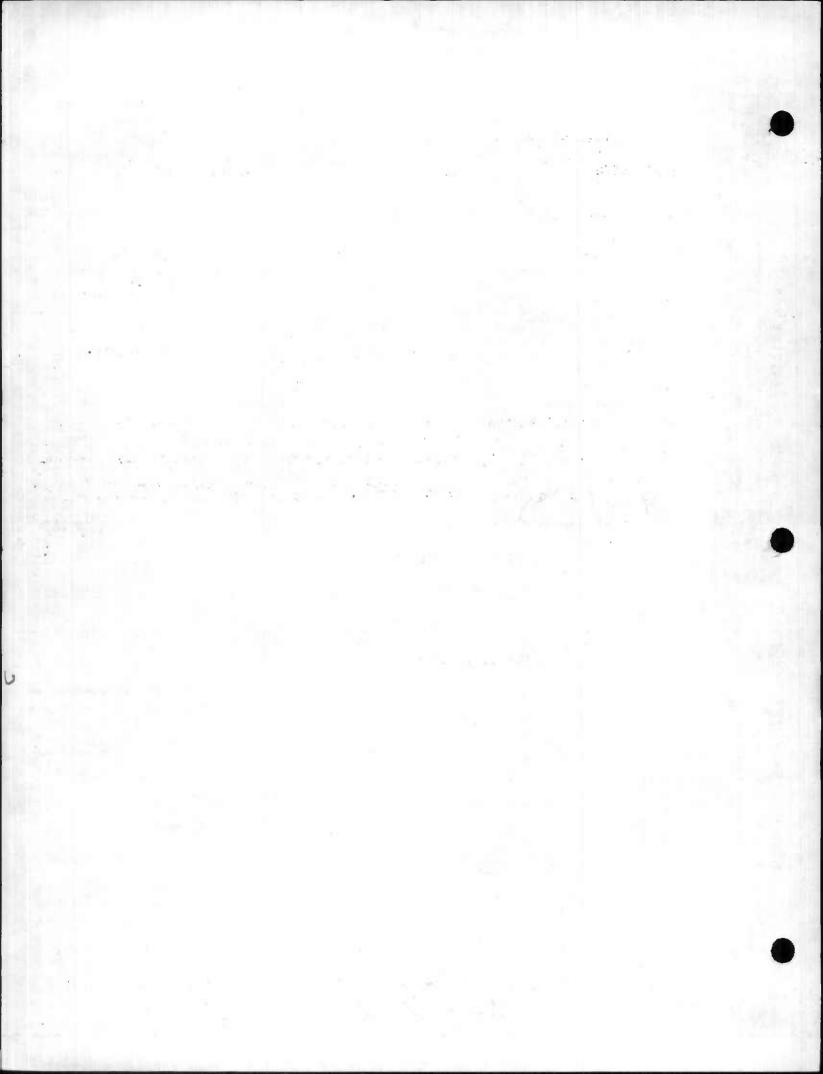
8218 Wisconsin Avenue #105, Bethesda, Maryland Albert K. Lee, M.D., 20814-3107

State Registrar 31. Data filed (Month, Day, Year) SEP 08 1998

6 ☐ Could not be



28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)



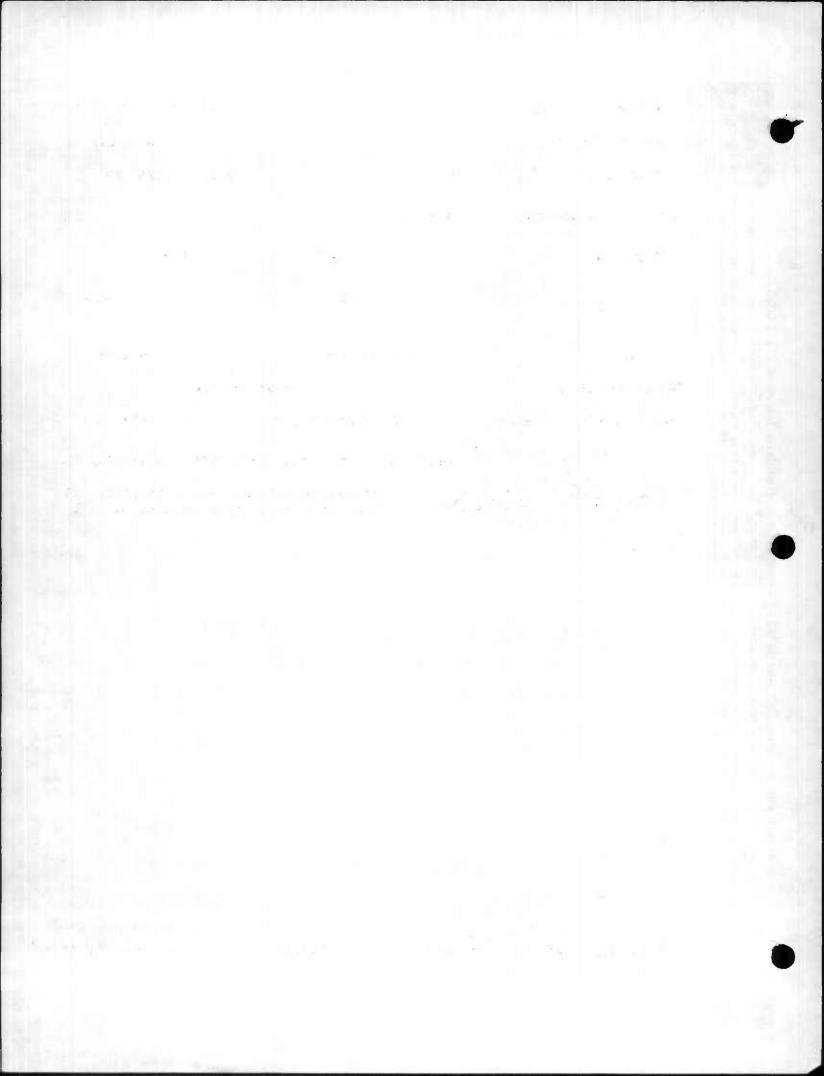
State of Maryland / Department of Health and Mental Hygiene | |

				Certific	cate of	Death		F	Reg. No.					
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	Suburban Hospit	a1				Bethes	da		Mont	gome	ry			
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or 28a-f s be notified Director	10e. Street and Number			10	f. Zip Code				10g. Citizen of V	Vhat Coun	itry?			
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* 5 10	1 Never Merried 2 Merried	1 ☐ Yes 2X If Yes, Give	1 Yes 2X No						Specify	: Wh	ite			
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g Ph	27. Manner of Death	28a. Date of In (Month, D	jury 28b.	Time of Injury	28c. Inju	iry et		28d. Describe	now Injury occur	red				
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be or Attending P is after death. al Director: After t led in by the funer. Certification:		3,	Sto. (0,000))											
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be	one)	end menner		TO HIVESTIS			00001							
To the Com	29b. Signature and title of certifier	101	1 -		_	se number			29d. Date signe		*			
10	Barret	Kent	(m)		D39	1190			Sop ten	ber 4	11998			
,	30. Name and address of person wh	o completed cause of	deam (Item 23e)	(Type, Print)					U					
	J. Garrett Reil	ly 11510 0	ld Georg	e Town	Road	Rockv	<b>i11</b>	e Maryla	and 2085	2				
State	31. Date filed (Month, Day, Year)		trer's Signeture	1.	1									
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Registrar DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



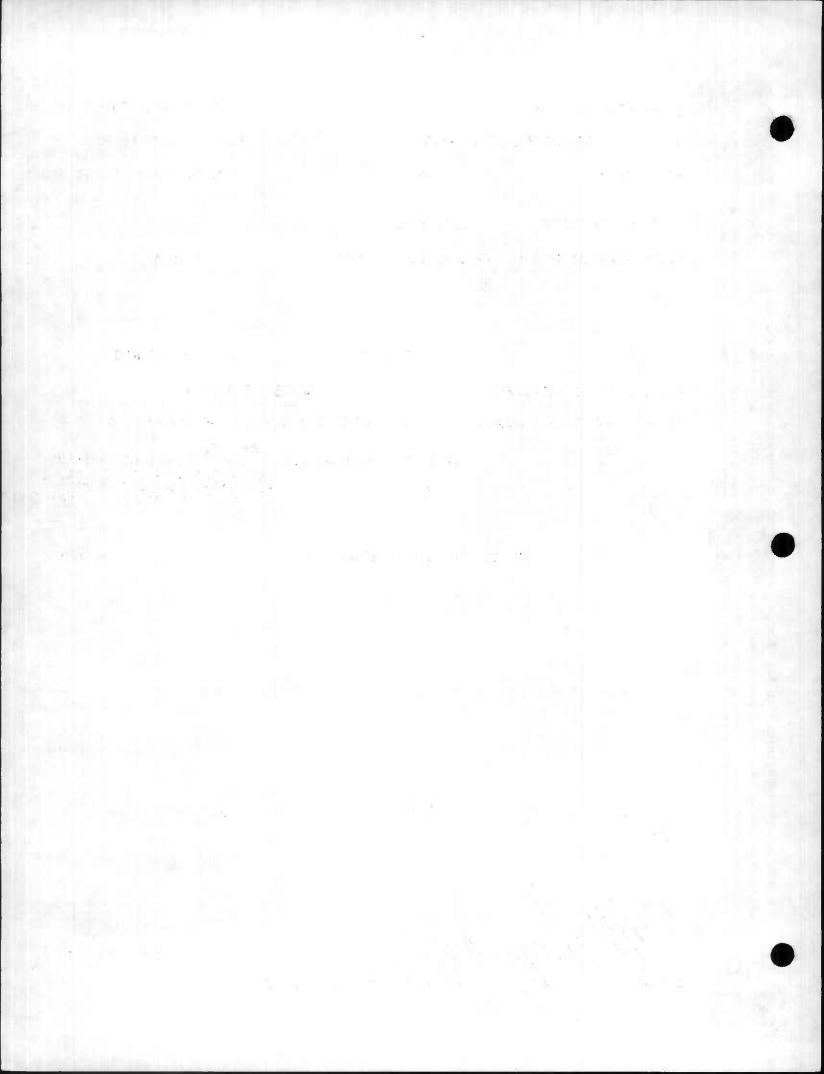
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 3. Time of Death 2. Data of Death Month Day **Physician** ALICE McQUAIN BLUSH SEPTEMBER 7th, 1998 6:30 A.M. /Medical 4e Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 11235 OAK LEAF DRIVE, APT. #1416 SILVER SPRING MONTGOMERY If Under 1 Year If Undar 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplaca (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** 1 M 2XX 64 Yrs. Days Hours Months Director 232-54-5714 NOV. 26, 1933 WEST VIRGINIA Usual Rasidance of Decedant the Maryland 10c. City. Town or Location r 28a-f show 10a State 10b. County 10d Inside City Limits 1 Yas XX No Directo MARYLAND MONTGOMERY SILVER SPRING 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 0 8 with "natural", or items 23a U.S.A.

14. Rece - American Indian,
Whita, etc. 11235 OAK LEAF TERRACE, APT. #1416 20901 Funeral death 12. Wes Decedant Ever in U.S.
Armed Forcas?
1 Yas XXXIVo
If Yas, Giva
Yaar or Datas: 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 72 hours after 1 Never Marriad 2 Married Baltimore, Maryland 21215-0020 Specify: WHITE 1 Yas 2X No Specify: p 3XWidowed 4 □ Divorced then 'neture Completed Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Hygiene. 12th PHARMACY GIANT FOOD 7 is marked other traumatic event, t 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Pages 1 and 2 should be facilities of Health and Mental Intel It Nem 27 is marked of ROSIE BELLE McQUAIN HARRY CLIFFORD GILLISPIE 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a, Informant's Name/Ralationship (Type, Pnnt) KAREN RENEE BLUSH (DAUGHTER) 10212 DUVAWN PLACE SILVER SPRING MARYLAND 20902 Kem 2. 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stata 20e. Mathod of Disposition Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State SEP. = 8 1998 4 Donation 5 ☐ Othar (Specify) FORT LINCOLN CREMATORY BRENTWOOD MARYLAND 22. Nama and Addrass of FacilityHINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE re of Funeral Service License SILVER SPRING MARYLAND 20904-2891 death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata Interval Batween Onset end Deeth Physician /Medical Immediate Cause (Final METASTATIC ADENOMA CARCINOMA disease or condition resulting in death) 4 MONTHS Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events reported.) Due to (or as a consequence of): physician is the burish Box 68760 8 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 8 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 XUnknown bengs be del Records, þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? frector, page 2 s 1 □ Yes XX No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home XX Residence 6 Other (Specify) 2 1 Yes 3CXNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 9 Manner of Death 28d. Describe how injury occurred Certification: 25a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Affair Athending (XX)Natural 5 ☐ Pending 1 Yes 2 No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Direc 4 THomicide b hours 29a, Certifier X Certifying Providen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the To the 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) D08754 SEPTMEBER 9th, 1998 0 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

State Registrar

THOMAS A. BENSINGER, 31. Data filed (Month, Day, Year) 32. Pegistrer's Signetura SEP 1 0 1998

MD., 7525 GREENWAY CENTER DRIVE, SUITE 205 GREENBELT MARYLAND



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month Year **Physician** Edward Edison Bockhaus September 5, 1998 3:25 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 01ney If Under 24 Hrs. Montgomery General Hospital Montgomery If Undar 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 15 M 2□ F Months Days Hours **Director** 579-07-4984 Oct. 25, 1915 South Carolina Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a Stata 10b. County r 28a-f show 1 Tyas 2 □ No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours efter death with the Department of Health and Mental Hygiena.
Important If Itam 27 is marked other than "non-11809 Timber Lane Funerai 20852 12. Was Decadent Ever in U,S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Datas: WW II Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritai Status Biack, Whita, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No Specify: þ 3 ⊠ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Accountant Columbia Specialty Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Nama (First, Middle, Last) Edward C. Bockhaus Augusta M. Schultz 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) (son) Olney, Maryland 20832 Date 20c. Location - City or Town, Stata Alfred E. Bockhaus 4004 Mount Olney Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 9/8/98 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** immediate Cause (Final disease or condition resulting in deeth) /Medical 30 DAYS SEPSIS Examiner Due to (or es a consequence of): Examiner 30 DAYS RENAL Pailure physician and the bunal-transit requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): 30 days multiple myeluns P.O. Box 68760 Physician/Medical Due to (or as a consequence of): attending p 98 signed by tha a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ORGANIC BRAIN SYNGROME Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed is certificate has director, page 2 1 ☐ Yes 2 No 1 Yes 21 No Attending Physician: 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) Hospital: 1 popatient 2 ER/Outpatient 3 DOA 1 ☐ Yes > No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funerai 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Divatural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No n 24 hours after death.

• Funeral Director: A pletely filled in by the fi death. investigation 6 Could not be determined 3 Suicida 28e. Piaca of Injury - At home, farm, streat, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homlcide ò edicai Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one)

10+1

Registrar

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUHOEN GOLD, MO 32. Registrar's Signature

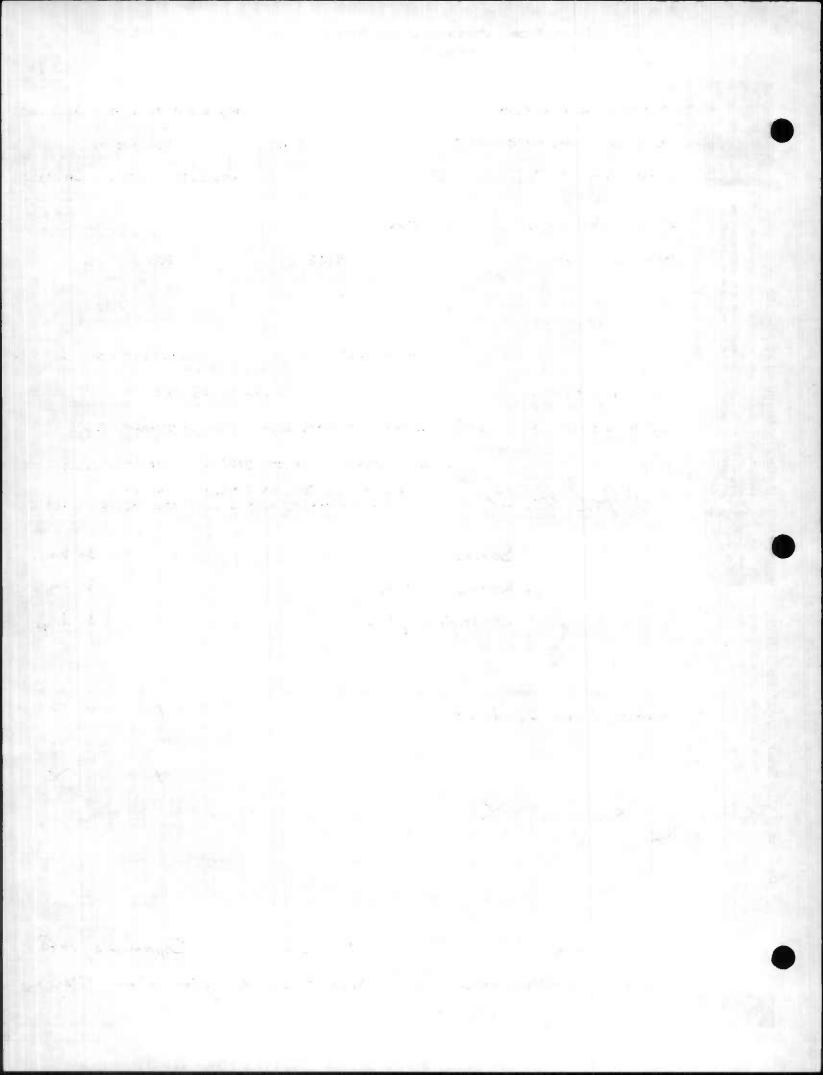
18101 PRINCE Philip Dr. OLATY, MARYLAND

29c. Licansa number

D18726

29d. Date signed (Month, Day, Year)

SEP 08



ALFRED VICTOR BOERNER

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Boerner,

Alfred

LOCKE

1998

32. Ray strar's Signatura

31. Data filed (Month, Day, Year) SEP 11

Facility Nama (If not Institution, give street and number) SUBURBAN HOSPITAL

Victor

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	State of Maryland / Department of H	ealth and Mental Hygiene
OR BOERNER	Certificate of I	Death Reg. No.
1. Decedent's Nama (Fi	irst, Middla, Last)	2. Data of Death

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Day

8,

SEPT.

4b. City, Town, or Location of Death

BETHESDA

Yaar

4c. County of Death
MONTGOMERY

1998

3. Time of Death

1840 PM

Physicia /Medica Examine	
Funeral Director	

pemit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Inspertment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show sny Injury or other traumatic event, if a Medical Examiner must be notified at once. Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Box 68760,

Division of Vital Records,

attanding physician and for use as the burial-transit signed by the a been significant Aftar this certificata has funeral director, page 2: Aftar

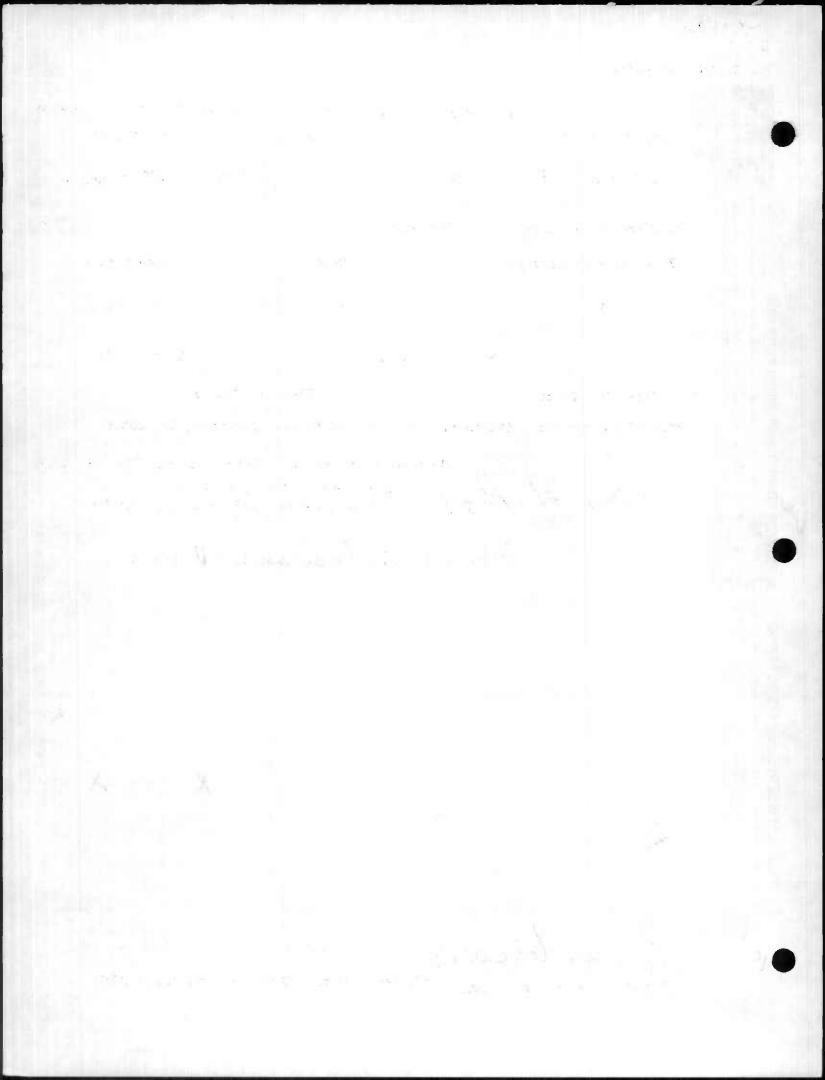
The law requires that the death certificete be assecuted or Attending Physician: r death. 3 24 hours after a Funeral Direct Hospital To the Hosp within 24 ho To the Fund complately f b

8. Data of Birth (Month, Day, Year) Feb. 13, 1 If Undar 1 Yaar | If Undar 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplaca (State or Foraign Country) Months 1 M 2□ F 220-34-4332 59 1939 Michigan Usual Rasidanca of Decedant 10c. City, Town or Location 10d. Insida City Limits 10b. County 1 Yas 2 No Directo Maryland Montgomery Bethesda 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Coda 20814 United States 7740 Wisconsin Avenue Funeral 12. Was Dacedant Ever in U.S. Armed Forces? 14. Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yas, Giva 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2 No Specify: by Specify: 3 Widowed 4 Divorced White Year or Datas: Completed 16a. Dacadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Collega (1-4or 5+) Elemantary/Secondary (0-12) 5+ Lawyer U. S. I. A. 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Eleanor Deming Alfred V. Boerner 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a, Informant's Name/Ralationship (Type, Print) 6004 Welborn Drive, Bethesda, MD Michael P. Boerner (brother) 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 9-10-98 Beltsville, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) Chesapeake Crematory 22. Name and Address of Facility
Rapp Funeral Services, P. A. 21. Signature of Funaral Sarvice Licensee/ 933 Gist Avenue, Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata triterval Batween Onsat and Daath Immediata Causa (Final disaasa or condition rasulting in daath) Dua to (or as a consequance of). Examiner Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequanca of): Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings availabla prior to completion of causa of daeth? 24a. Was an autopsy performed? Completed Yas Be 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2XX PR/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 15 Yas 2□ No 10 27. Mannar of Death
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2 Accidant 28a. Data of tnjury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of Certification: 5 Panding invastigation 1 Yas 2 No 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Straet and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homlcida 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian edicai (Check onli 29b. Signa 29c. License number 29d. Data signed (Month, Day, Year) SEPT. 9, 1998 O.C.M.E 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 - LARON

Registrar **DHMH 16 Rev 6/95** 

State



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 8 8;05PM Helen Boyden Sept 1998 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17300 Quaker Lane Apt #D 23 Sandy Spring Montgomery If Under 1 Yaer | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M NOW 028 16 8101 Yrs. 88 Director Rhode Island June 29 1910 Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show Md Montgomery Sandy Spring X□Yes 2□No Director 288-4 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or itsms 23s or 17300 Ouaker Lane Apt # D 23 20860 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, Whita, etc. 1 Yes X No
If Yas, Give
Year or Datas: filed within 72 hours after Nevar Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 € No Specify: Specify: White À 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Dietitian School permit. Pages 1 and 2 should be filled with Department of Health and Mertal Hygien important: If flum 27 is marked other that any injury or other traumatic event me. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be Ida B. Terry Eugene M. Boyden 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Ralationship (Type, Print) Elizabeth Boyden/Sister 2103 E. Lawndale Dr., San Antonio, Texas 78209 20b. Place of Disposition (Name of cometary, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Dete 9 / 08 George Washington Univ 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Washington DC 4 Donation 5 ☐ Other (Specify) Medical Center Columbia Mortuary Services and Funeral Service List PO Box 58007, Washington DC 30037 23a. Part1. Enter the disease, or complications that ceused the death. Do not entar tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only one cause on each line. Approximate Intervet Between Onset and Death **Physician** /Medical Immediete Ceusa (Final SP: -D-E ell SOFT TISSUE SARCOMA disaase or condition resulting in deeth) Examiner Due to (or as e consequence of): Examiner RIGHT BREM physician and the burial-fransit the death certificate be executed Sequentially list conditions, if any, leeding to immediate causa. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of) Box 68760, Physician/Medical Due to (or es a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown þ should I 24b. Ware autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 Yas 200 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, i 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa Sesidence 6 Other (Specify) 1 Yes 2 No edicai Certification: To 27. Manner of Deeth 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 5 Panding invastigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledga, deeth occurred at the tima, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signature and til 29c. License number

State Registrar

Joseph

32. Registrar's Signature

30. Name and address of person who completed ceusa of death (Item 23a) (Type, Print)

KARIN

31. Dete filed (Month Day Year) 1998

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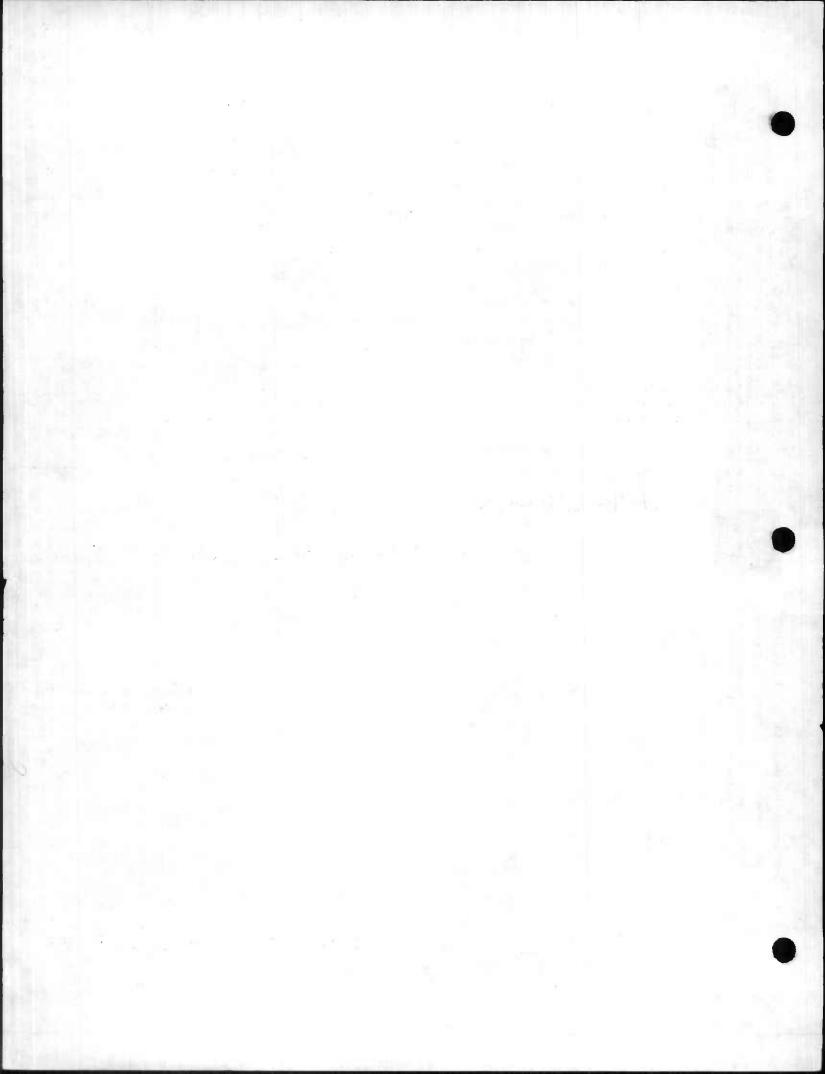
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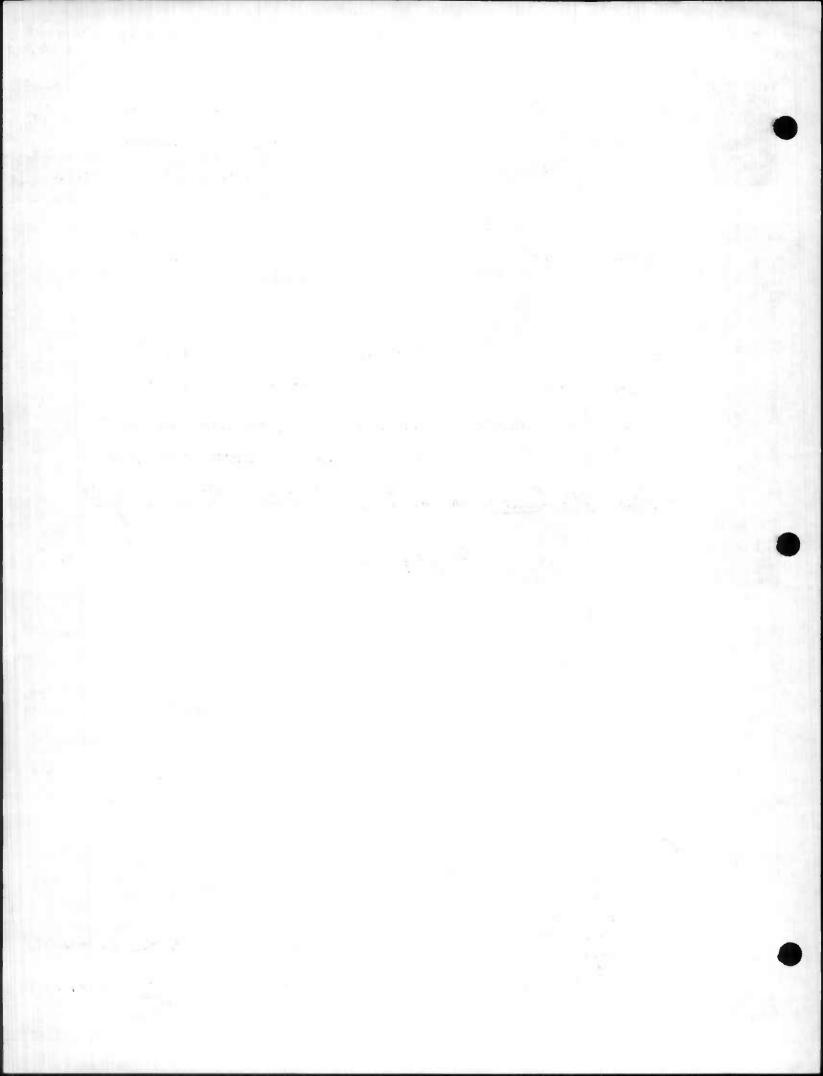
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State of Maryland / Department of Health and Mental Hygiene

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/Medi		Thomas Charles		4. 65. T	Sept.	7 19								
Exami	ner	4a. Facility Neme (If not institution, giv		)			r Location of Deer							
		185 Bowery Stre				li I ladau		Frostbur		Allegany				
Funeral Director		5. Sociel Security Number 6. S 048 05 5586 Usuel Residence of Decedent	60 55 -	7. Age (In yrs. last birthday) 77 Yrs. Hunder 1 Year off Under 24 Hrs. Nov. 27 1920 1 Under 1 Year off Under 24 Hrs. Nov. 27 1920						rth ey, <i>Year)</i> 7 1920 C	9. Birthplece (State or Fore Country)  Connecticut			
show	٥.	10e. State 10b. County		10c. City, To		cation					10d. Inside City Lir			
28a-	ecte	Maryland Allegany		Frostb	urg		- 1				A			
23a or 2	al Director	10e. Street and Number 185 Bowery Stre	et	10f. Zip Code 21532						U.S.	net Country?			
ral Hygiena. d other than "natural", or ferna 23a or 28a-f show event, the Medical Examinet must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Wes Deceden Armed Forces 1 ☑ Yes 2 ☐ If Yes, Give Yeer or Detes:	<sup>?</sup> № 1943-		Ves Deced Yes, spec		lispenic Origin? ( en, Mexicen, Pue Specify:	Specify Yes or Norto Ricen, etc.)		- American Indien, White, etc. White			
th end Mental Hygiena. 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Completed by	15. Decedent's Ed (Specify only highest gre	ducetion	1740	740						iness/Industry			
	Сотр	Elementery/Secondary (0-12)	College (1-4or	5+)	Bottle Handler Fo						pany			
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Merke	10	Charles H. Brow							ce G. 0'					
is m			a. Informent's Name/Relationship ( <i>Type, Print</i> )  19b. Melling A							ber, City or Town, S	tete, Zip Code)			
Health e		Jeffrey A. Harp	er/Cousin						rostbur		1532			
Depertment of Health Important: If item 27 any injury or other to once.		20e. Method of Disposition  1 Durial 2 Cremetion 3 D	Removel from State	20b. Plece ceme	of Dispos tery, crem	sition (Ner letory or o	ne of ther ple	ce)	Dete	20c. Location - C	- City or Town, Stete			
		4 □ Donetion 5 □ Other (Specif		Cumb	Cumberland Crematory 9/					Cumber1a	and, Md.			
Medical caminer	Examiner	fmmediate Ceuse (Finel disease or condition resulting in death)  Sequentially list conditions, if eny, leading to immediate	ө b	Due to (or es							20 yr			
attanding physician end I for use as the bunal-transit	Physician/Medical E	Sequentielly list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Lest												
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	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  A J Dolline 70 922 N2+1 Huy 62 V212													

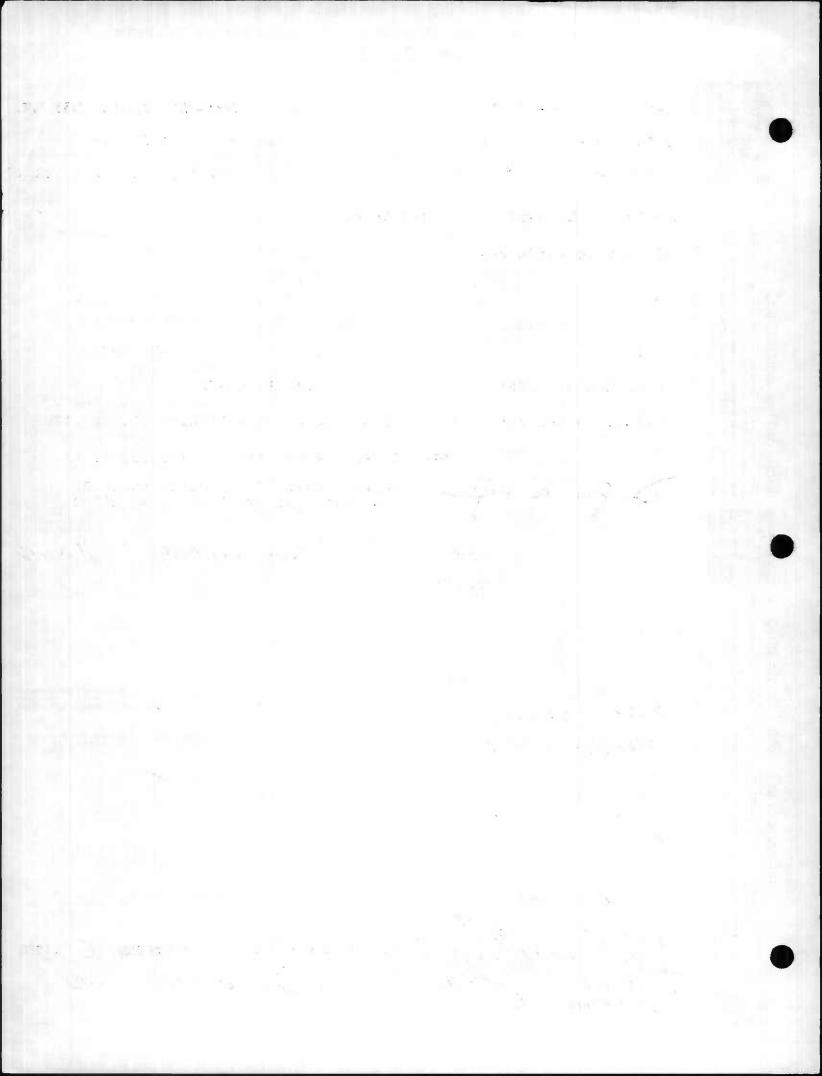
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State of Maryland / Department of Health and Mental Hygiene 2 8 9 6

					Cer	tificat	e of	Death		Re	g. No.						
		1. Decedent's Name (First, Middle, I	.ast)							2. Date of Deat			3. Time of	Death			
	sician	HELEN	1. BARB							Month SEPTEMI	Day BER	3.1998	3:55	P.M.			
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Fune	ral			ga (In yrs. le:	st birthday)	If Unda	1 Yaar Days	If Under:		8. Date of Birth	Date of Birth (Month, Dey, Year) 9. Birthplaca (Steta or Fore						
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ath with the Marylan 23s or 28s-f show	Director	10e. Street and Number				10f. Zip				1		n of Whet Count	ry?				
ath w	<u>e</u>	12716 WINCHES						1502									
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d within 72 hours aff giene. or than "natural", or	by F	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	HAO	1	☐ Yes	2 💢 No	Specify:			Sp	pecify: WHI	TE				
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should be and Mentel		GEORGE EDWI	JUDY					CARR	IE	LANTZ							
d 2 should be file th and Mentei Hy 7 is marked other traumatic event	F	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing	g Address	(Street	end Numbe	r or Rur	el Routa Number	City or T	own, Stete, Zip	Code)					
C = 0 +		CHARLOTTE M L	OHR/DAUGH	ITER	8815	UT	OPI	A PLA	CE	WALKER	SVIL	VILLE, MD 21793					
s 1 en f Healt item 2		20a. Method of Disposition		con	nce of Dispos	sition (Ne	ne of	ce)		Date	20c. Loca	tion - City or To	wn, State				
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To the Hospital or Attend within 24 hours after deel! To the Funeral Director: completaly filled in by the	edical	(Check only & Madical Expone)	aminer: On the basis of and menner si	tated tated	on and/or inv	estigetion	, in my o	opinion, dea	th occur	red at the time, d	ate ena pi	lece, and due to	the ceuse(s	-)			
within 2 To the	×	29b. Signature and titla of certifier.	12/1	/		29	c. Licens	sa number		2	9d. Date :	signed (Month, i	Day, Year)				
10		Morning	19/h	14/1	/ PS	7	1)3	5/	35		SEPTI	EMBER	6.	1998			
hil		30. Name and address of person wh	o completed caus/of	death (Item 2	23a) (Type, F	Print)	,	^		1		, ,					
TUNS		IROMAS E.	man/11	mo	91	750	401	n V	Li	( ums	ev/	and 1	mo				
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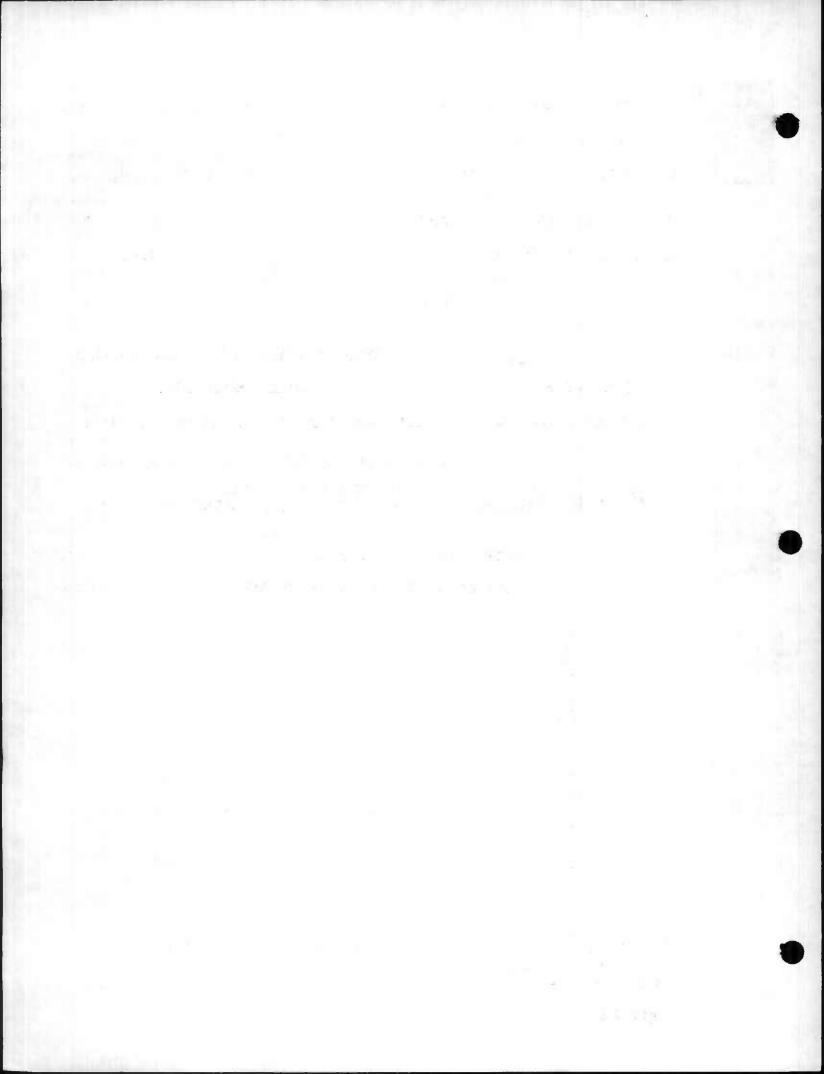


ACHD - ekc con. #1 + 20b 9-4-98 Letter obtaine per Mas 9/21/98 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** FRANCES LAINGER LAWLER BAKER SEPT. 1, 1998 1:15 PM /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND ALLEGANY MEMORIAL HOSPITAL If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days 74 Yrs. Director 218-12-5620 AUG. 1, 1924 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b. County a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits Yes 2 No Director MD ALLEGANY CUMBERLAND 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours eftar death with ns 23a 10 N. LIBERTY 21502 STREET U.S.A. Funerai items ; 11. Maritai Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. "neturel", or iten 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☐ No þ Specify: WHITE 3 ₩idowed 4 Divorced Completed th and Mental Hygiana.
7 Is marked other than "netur traumatic event, the Meoles. 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) MENTAL HEALTH ASSOCIATE/LPN MENTAL HEALTH Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be facent of Health and Mental I in it item 27 is marked o LEO THOMAS LAWLER LILLIAN MARIE LAING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUE SCHULTEN / DAUGHTER 1212 BEDFORD STREET, CUMBERLAND, MD or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Locetion - City or Town, Stete 1 Buriai 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) SS.PETER & PAUL CEMETERY 9/4/98 CUMBERLAND, MD 21. Signature of Funeral Service Licensed 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fellure. List only one cause on each line. Approximate Intervai Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical ACUTE MYOCARDIAL INFARCTION IMMEDIATELY Examiner Due to (or es a consequença of) Examiner 20 YEARS HYPERTENSIVE CORONARY ARTERY DISEASE The law requires that the death certificete be executed buriel-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue Due to (or as a consequence of) Box 68760. Physician/Medicai the Due to (or es e consequenca of): SB for use P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown TYPE II DIABETES Records, by 8 24b. Were autopsy findings svaliable prior to completion of cause of deeth? Completed 24a. Was an autopsy performed' page 2 certificata 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funerel director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Investigation 1 Naturai hin 24 hours efter death. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 - Homicide Hospital 15 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date end pieca, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pieca, and due to the cause(s) and menner stated. Medicai 29a, Certifier pletely (Check only one) the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 5 1217565 OKE 1 30. Neme end address of person who completed cause of death (item 23e) (Type, Print) J. Bollin no Highway 62 V212 17 1 21502 911 Nation 21 31. Date tiled (Month, Day, Year) 22. Registrar's Signature

Registrar

SEP 0 4 1998



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth September poys, 1998 **Physician** BAKER Viola Caroline 6:09 pm /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Northampton Manor Nursing Center Frederick Frederick If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1□ M 2□XF Days 212-74-1131 91 Yrs. 13, 1907 Maryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Jefferson Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2723 Jefferson Pike 21755 U.S.A. Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ②No If Yes, Give Year or Detes: 1 Never Merried 2 Married 1 Yes 2 XNo Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Charles STALEY Ezra Edith Alvesta. SMITH 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Caroline B. Gastley/Daughter 6615 Tuscarora Drive, Frederick, Maryland 21702 20b. Plece of Disposition (Name of cometery, crematory or other pleca) 20e. Method ol Disposition 20c. Location - City or Town, Stete tX Burlai 2 ☐ Cremation 3 ☐ Removel from State Mt Olivet Cemetery Sep 9, 1998 Frederick, Maryland 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funerel Service Licansee <sup>22</sup>, Name end Address of Facility Keeney & Basford P.A. Funeral Home M00021 106 E Church Street, Frederick, Maryland 21701 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Betw Onset end Deeth immediete Ceuse (Final diseese or condition resulting in death) Dementia 1 year Due to (or es e consequence ol) Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequença ol): Physician/Medicai Due to (or es e consequence ol) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Congestive Heart Failure; Renal Insufficiency; Completed by 24e. Wes en eutopsy performed? 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Hyperparathyroidism; arthritis; gastro-esophygeal reflux; hypertension 2 DINO 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpetient 3 | DOA 1□ Yes 2□ No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Sulcide 28l. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, lerm, street, factory, offica building, etc. (Specify) 4 Homleide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) end menner steted. 29a. Certifier 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) D47169 September 06, 1998 would 30. Name end eddress of person who completed cause ol deeth (Item 23e) (Type, Print) Chan-Hing Ma Ho, M.D., 610 Ninth Avenue, Brunswick, Maryland 21716 31. Dete filed (Month, Day, Year) 32. Registrays Signature

State Registrar

**Funeral** 

Director

ral', or items 23s or 28s-f show Examiner must be notified at

e filed within 72 hours after de il Hygiene. other than "netural", or Item vent, The Med all Exeminat

permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic event, the 2005.

**Physician** /Medical

Examiner

physician and s the burial-trans

been signed by the a should be detached

page 2

funeral director,

certificate

this

After

within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu

P.O. Box 68760.

Division of Vital Records.

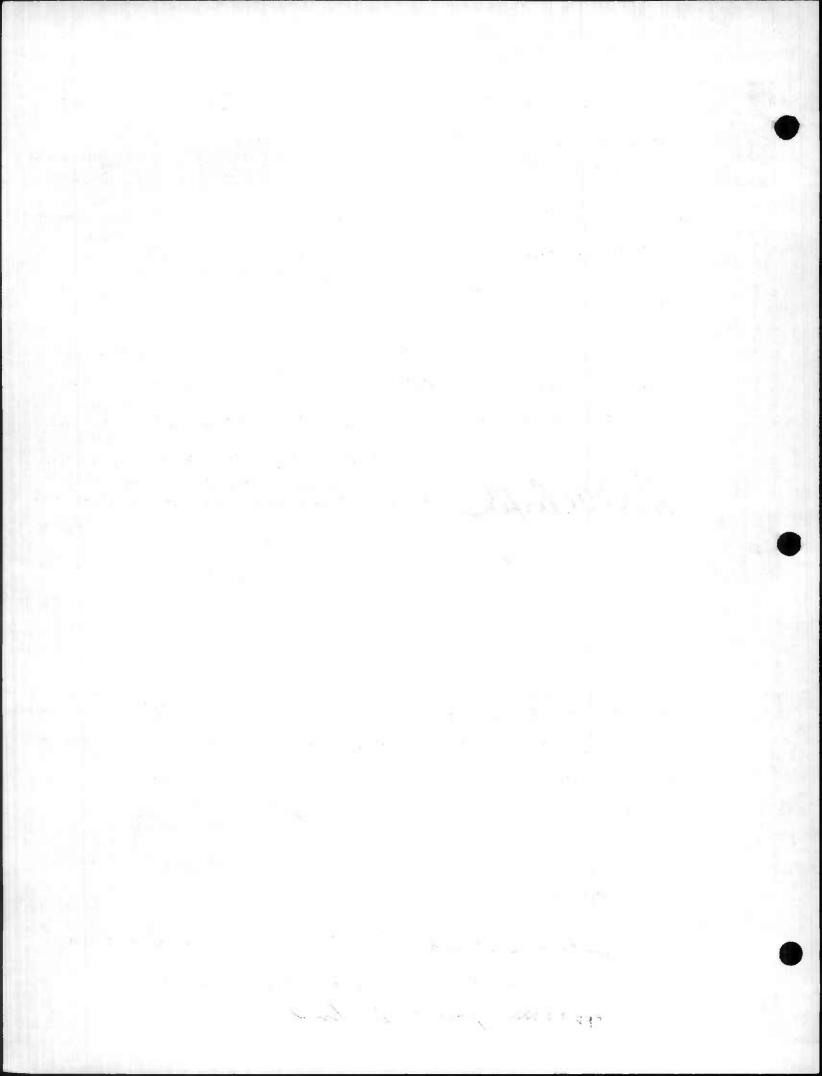
Hospital or Attending Physician:

To the

Baltimore, Maryland 21215-0020

with the Maryland





State of Maryland / Department of Health and Mental Hygiene 0 0

a. Facility Nama (If not Institution, give 7617 Old Recei Social Security Number 217–10–9695 Insuia Residence of Decedent Oa. State 10b. County Maryland Frederi Ob. Street and Number 7617 Old Receive 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest grant Elementary/Secondary (0-12) Ob. Teather's Name (First, Middle, Last) Charles 9a. Informent's Name/Relationship (Mrs. Frances Bur Ob. Method of Disposition	Martin B a streat and number) Ver Road Sex 7. Age 8 Ck Fer Road  12. Was Decedent E Armed Forces? 1 M Yes 2 D N 17 Yes, Give 10 Year or Dates.  Sucation Ide completed) College (1-4or 5+	reder ver in U.S. 43–1943	thday) If Under 1 Year Months Days on or Location cick  10f. Zip Code 217	4b. City, Town, or Lo Frederi I Under 24 Hrs. Hours Min.  O2 Hispanic Origin? (Spoten, Mexicen, Puerto	2. Data of Deat Month September cation of Death Ck  8. Data of Birth (Month Day, April 2)	4c. County of D Frede 2, 1912	eath  rick Birthplace (Sta Country)  10d. Inside 10V  Country?  merican Indian Thite, etc.	e City Limits /es 2 No				
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	Mrs. Frances Burdette, wife 7617 Old Receiver Road, Frederick											
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9b. Signature and Mile of cedifier	1		29c. Licar	nsa number	2	9d. Data signed (Mo	onth, Day, Yea	r)				
1160	Poblison	att.	MO D	35/83		9/01	100					
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Was case referred to medical examiner?  1   Yes 2   No  Month, Day Year)  Hospital:   Dipatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Hother   1   Matural   1   Matural   1   Matural   1   Matural   1   Matural   1   Matural   1   Matural   1   Matural   1   Matural   2   Month, Day Year)   28b. Time of Injury   28c. Injury at Work?   1   Yes 2   No   28c. Place of Injury   At home, farm, street, factory, office   3   Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.  Name so laddress of parson who contributed cause of death (Type, Print)   3   So	4 Contain 5 Other (Specify)  1. Signature of Funeral Service Licensee    Mode	Signature of Funeral Service   Sept.   S.   1998   Frederick	Signature of Funess (Specify)   Mount Citative Centerery Sept. 8, 1998   Frederick, Mary. 1. 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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month Dey MILDRED V. BOYER 3, Sept. 1998 6:55 AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Frederick Health Care Center Frederick Frederick 5. Sociel Security Number If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year)
Dec. 16, 1920 Maryland 7. Age (In yrs. lest birthday) **Funeral** 10M F Deys Hours 217-10-0802 77 Yrs. Director Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is merked other than "natural", or items 23s or 28s-1 show any Injury or other traumatic event, the Macinal Examinat must be contained. 10a. Stete 10b County 10c. City, Town or Location 10d. Inside City Limits TE Yes 2 No Director Frederick Maryland Frederick 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 417 Columbus Avenue 21702 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ♣☐ No If Yes, Give Yeer or Dates: 11. Maritel Status Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 ₩idowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Beauty Shop Beautician 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surneme) Edward Walker Miss Della H. Whipp 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Eugene F. Rinehart (Nephew) 5301 Mussetter Road Ijamsville, Md. 21754 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1X Burlal 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 9/8/98 Frederick, Maryland 21. Signeture of Eugeral Service Licensi ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 death. Do not enter the mode of dyling, such as cardiac or respiretory errest, **Physician** /Medical Immediate Cause (Final 5 YRS MPHYIEMA disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner physician and s the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): ettending for use es P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown been signed by should be detec Records, þ Completed 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? page 2 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director. 25. Wes case referred to medical Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this s s efter death.
i Director: After this
od in by the funeral d 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral C completely filled Hospital 29a. Certifier 1 Acertifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner stated. edical To the I 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) arow ms D47611 9-3-98 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Neil V. Waravdekar, MD 1475 Taney Avenue, Frederick, Maryland 21701 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar SEP 04

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death **Physician** August 29, 1998 Alma Victoria 11:00 AM /Medical 4a. Facility Name (If not institution, giva straet and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood Retirement Center Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplaca (State of Borth) | April 27, 1909 | 9. Birthplaca (State of Pennsylvania) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (State of Borth) | 9. Birthplaca (St 5 Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplaca (State or Foreign **Funeral** 1 ☐ M 2 💢 F 216-48-6364 89 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Maryland Frederick Frederick 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 31 West Patrick Street 21701 U.S. A. Items 23a Funeral 12. Was Decedent Ever in U,Š. Armed Forces? 1 ☐ Yes ≥ ŽŽ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiane. Important: If Itsm 27 Is marked other than "natural", or iter any injury or other traumatic event, the Medical Examination on the first interest of the Medical Examination. 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: Specify: White þ 3. Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meidan Sumama) Be William ARNVALL Hilda 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Sharyn R. Beckley, Daughter 6513 Putman Road, Thurmont, Maryland 21788 20b. Place of Disposition (Neme of cemetery, cremetory or other place)

Mount Olivet Cemetery, Sept. 1, 1998 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licenses 22. Name and Address of Facility. Keeney and Basford P.A. Funeral Home MO0255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one ceuse on each line. Approximate Interval Betwe Onset and Death Physician /Medical Immediete Cause (Finel disease or condition rasulting in death) Examiner Examiner Al 2 helmer physician and the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in daath) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by d be detact 1 Yes 20 No 3 Probably 4 Unknown Records, þ 24b. Ware autopsy findings availebla prior to completion of ceuse of death? Completed 24a. Was an autopsy performad? 2 No this cartificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

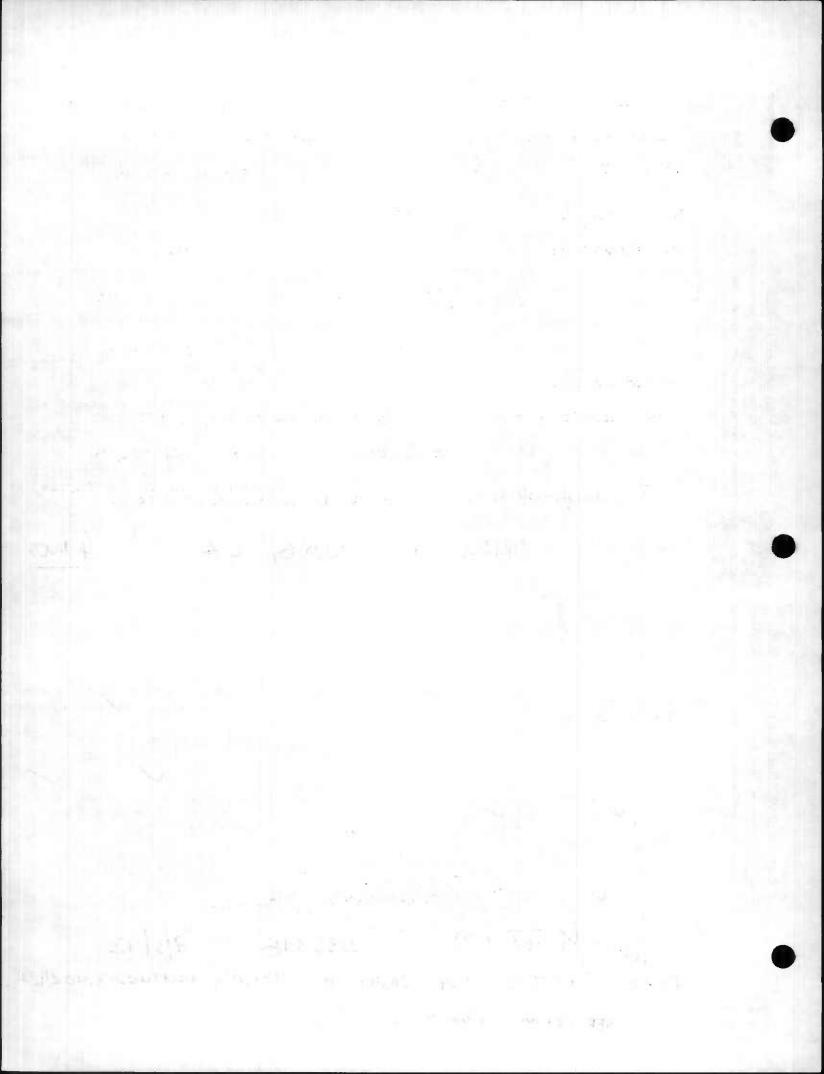
To the Funeral Director: After this cartifica completaly filled in by the funeral director; to Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA Other: Sursing Home 5 Residence 6 Othar (Specify) 1 ☐ Yes 2 No Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1. Qatural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide pertifying Physicien: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a, Certifier Medicai 29b. Signatura and titla of certifiar 29d. Date signed (Month, Dey, Year) 29c. Licansa numbar August 31, 1998 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) NINTH STRUET, FREDERICK,
MO 21701 JR. 300 WEST PEARRE 31. Date filed (Month, Dey, Yeer) 32. Registrar's Signature State AUG 3 1999 Registrar

State of Maryland / Department of Health and Mental Hygiene

1.77			450			(	Certifica	te of	Death			Reg. No	50	20	3961
Physician /Medical		1. Decedent's Name (First, Middle, Last)  Earl D. Burnette									2. Date of De Month Sept	3 Dey 1998			3. Time of Death 8:15am
Examiner	4a F			, giva street and no General		al			4b. City, Tow Westmi		r Location of Death 4c. County of Death Carroll				
Funeral Director		ocial Security N		6. Sex 1 M 2 ☐ F	7. Aga (In yrs		ndey) If Under	er 1 Yaar Deys	If Under a	Min.	8. Date of Bi (Month, De Sept 19	th ey, Year)		Birthpl Coun	lace (State or Fore try)
wow	10a.	al Residence o State	Decedent 10b. County Carrol	1			or Location				орс 13		25		0d. Inside City Lim
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gas 1 and 2 should be filed within 72 hours aff it of Health and Mentel Hygiane. If item 27 is marked other than "naturel", or other traumatic event, its Medical Earth or other Traumatic event, its Medical Earth or other traumatic event, its Medical Earth or other traumatic event, its Medical Earth or other traumatic event, its Medical Earth or other traumatic event, its Medical Earth or other traumatic event, its Medical Earth or other traumatic event, its Medical Earth or other traumatic event, its Medical Earth or other traumatic event, its Medical Earth or other traumatic event, its Medical Earth or other traumatic event, its Medical Earth or other traumatic event, its Medical Earth or other traumatic event, its Medical Earth or other traumatic event, its Medical Earth or other traumatic event, its Medical Earth or other traumatic event, its Medical Earth or other traumatic event, its Medical Earth or other traumatic event, its Medical Earth or other traumatic event, its Medical Earth or other traumatic event, its Medical Earth or other traumatic event, its Medical Earth or other traumatic event, its Medical Earth or other traumatic event, its Medical Earth or other traumatic event, its Medical Earth or other traumatic event, its Medical Earth or other traumatic event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event eve	Ele	(Specenantary/Secons		t grada completed	) (1-4or 5+)	or 5+)  16a. Decedent's Usuel C (Giva kind of work of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control			pation during most d)	t of workin			ind of Busi		32 B d
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To the Hospital or Attending Physician Completely filled in by the funeral Director: After the completely filled in by the funeral Medical Certification:	3	Suicide Homicide	6 Could n	ot be 28e. Plec	e of injury - At i ling, etc. (Spec	nome, fari	m, street, facto	ry, office		2	8f. Location City or To			or Rura	i Routa Number,
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State Registrar	31.0	ete filed (Mon	m, Day, Year)	32.	Registrar's Sign	nature	4	1.							,

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

				Certif	ficate of	Death	R	eg. No.	2	8968		
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Physician /Medical		ark					SEPTEM		1998	6:58 AM		
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	Sacred Heart H				(Under 1 Veer	Cumberla						
Funeral Director	5. Social Security Number 278–22–9789	6. Sex 1 ☐ M <b>2/CX</b> F	7. Age (In yrs. I 68		f Under 1 Year lonths Deys		(Month, Day	Year) 5, 1929		plece (State or Foreigntry)		
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C = 0 F	William A. Cla	rk	not D	19714 lece of Disposition emetery, cremate	Old Mi	ller Rd.	Barton,	MD 21		Chan		
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Physician /Medical Examiner	Immediete Ceuse (Finel disease or condition rasuiting in daath)	e. <u>S</u>		PER I		TIS		Н	7	Onset end Deeth		
ate be hysicia the bur	Sequentially list conditions, if any, leading to immedieta causa. Enter Underlying Cause (Disaase or injury thet initieted evants resulting in deeth) Last Due to (or es e consequence of):											
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1	30. Name end address of person	who completed seve	a of death /them	23a) (Tupo Pri	ot)			SEPTE	WREK	1998		
12	30. Name end address of person	V. M.D.	1068 NA-7	CONAC A	HGITWA ?	LAVA	LE, MA	CLANE	3 2	1205		
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State of Maryland / Department of Health and Mental Hygiene

asp ITEMS: #23 PART I, 27, 28A-F PER MEO G763 9-24-98 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 30 1998 **Physician** AUGUST Faith Constance Carter 2:15 A /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner HYATTSVILLE WOODED WAY & GREEN FOREST DRIVE PRINCE GEORGES If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) If Under 1 Yeer 5. Sociel Security Number 6 Sex Birthplace (State or Foreign
Country) **Funeral** Months Deys 1□ M 20XF 37 Yrs. 219 78 4566 Director Sept 20, 1960 Jamaica Usuel Residence of Decedent the Meryland 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Takoma Park 1 X Yes 2 ☐ No Montgomery rms 23a or 28a-f e Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7600 Maple Avenue 20912 Jamaica Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Hems Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Maritel Status traumatic event, the Medical Examiner. Bleck White, etc. filed within 72 hours efter 1 X Never Married 2 ☐ Married ò 1 Yes 2 No Specify: Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12 Child Care Attendant Child Care permit. Pages 1 and 2 should be file Department of Heelth and Mentel Hy, Important: If item 27 is marked othe any injury or other traumatic event, once 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Eric Carter Alice Richardson 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type. Print) Alice Carter/Mother 2805 Terrace Drive, #109 Chevy Chase, MD 20815 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 1X Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 9/8/98 Washington, D.C. Glenwood Cemetery 4 ☐ Donetion / 5 ☐ Other (Specify) 22. Name and Address of Facility 20012 McGuire Funeral Service, Ni 7400 Georgia Avenue, N.W. Washington, D.C. s, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medicat BLUNT FORCE INJURIES OF HEAD Examiner Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): pue physician Physician/Medical Due to (or as a consequence of) 9 2 920 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 Unknown bengs d be det Division of Vital Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy Yes 2 No Ves 20 No confinents 25. Was case referred to medical Be 25. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6XX0ther (Specify) SCENE 2 XX Yes 2 No 204 28b. Time of A 27. Manner of Death 28s. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: FOUND: 8-30-98 FOUND 2:10M 1 CNatural 5 Pending 1 Yes 200 No SUBJECT WAS ASSAULTED investigation 2 Accident i or Attend after deat Director: 3 C Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) WOODED WAY & GREEN 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 (X) Homicide FOUND: ON STREET FOREST DR., BELTSVILLE, MD. 24 hours of 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier edical (Check only To the To the To the F 29c. License number 29b. Signeture and title of certifier 29d. Date signed (Month, Dey, Year) ulane M.D O.C.M.E AUGUST 30,1998 30. Neme end addr ss of person who completed sause of deeth (Item 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Joseph estaner

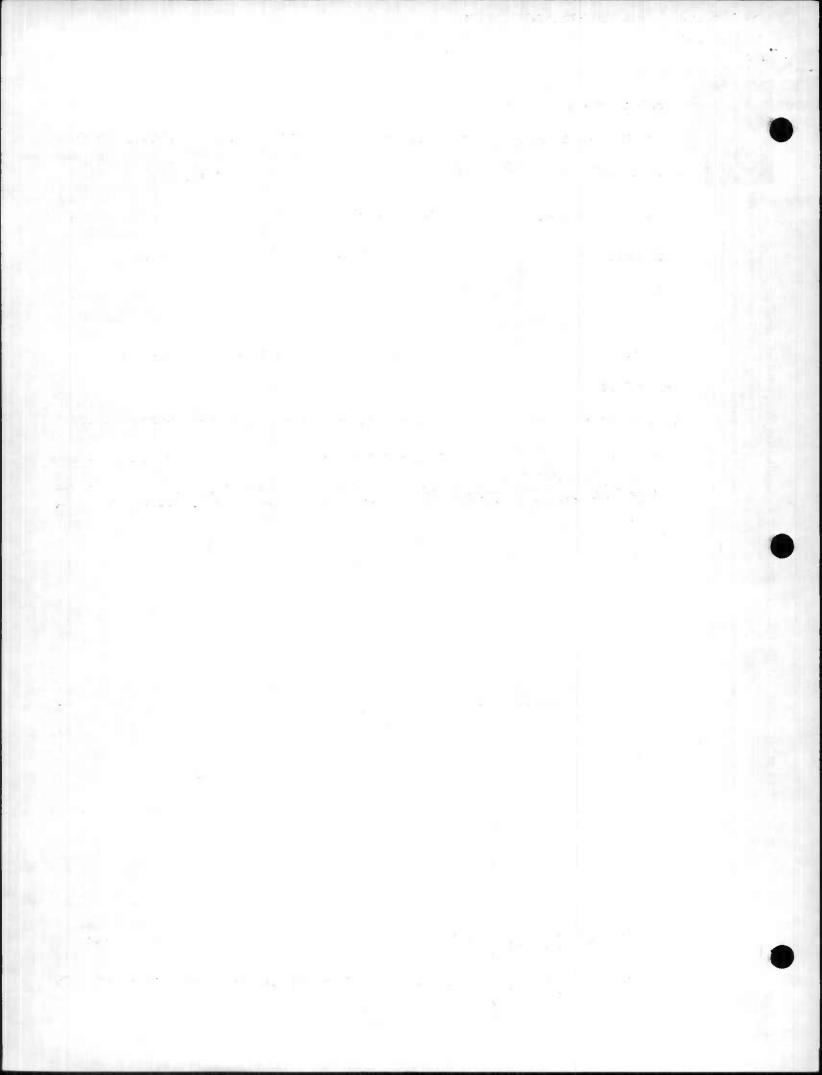
32. Begistrer's Signeture

Registrar **DHMH 16 Rev 6/95** 

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31. Dete filed (Month, Dey, Year)

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tate of Maryland / Department of Health and	Mental Hygien	e op	8970
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Phys /Me Exan

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Itam 27 is marked other than "natural", or Itama 23a or 28a-f show any Injury or other traumatic event, I're Medical Examinet must be notified at Baltimore, Maryland 21215-0020

Physician /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and purpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit

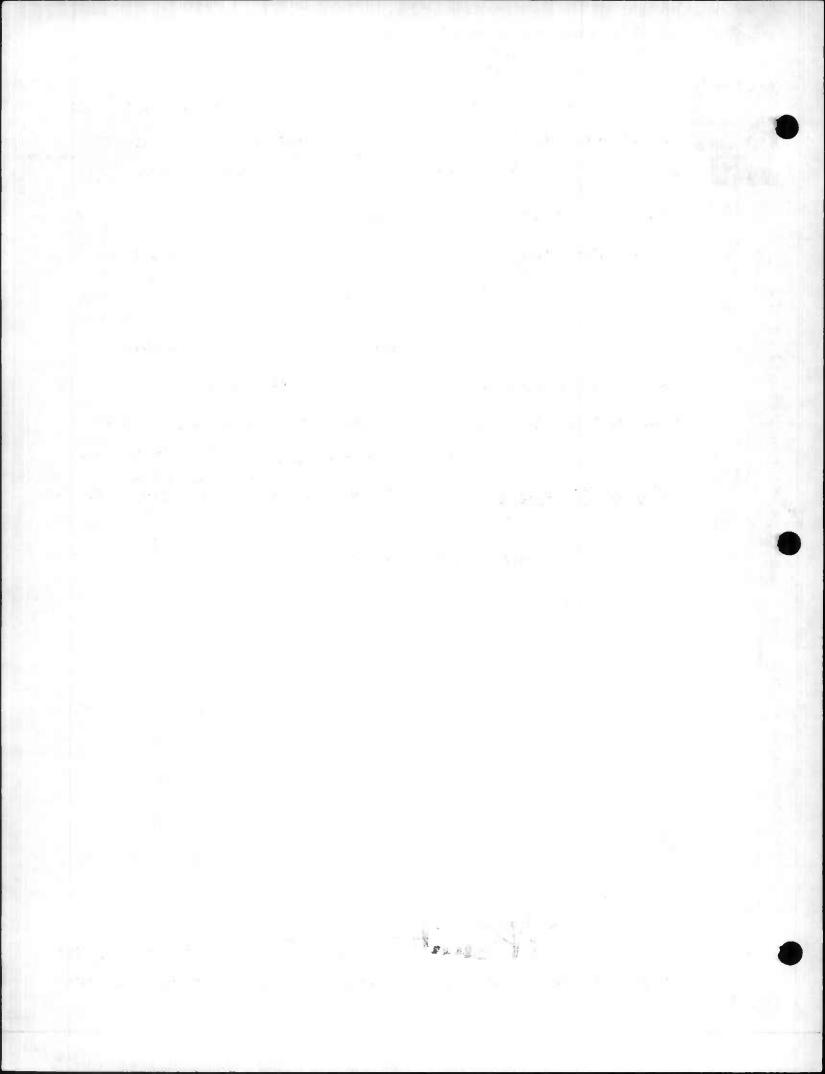
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Spale

32. Registrar's Signature

State Registrar 31. Dete filed (Month, Dey, Year) SEP 0 9 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Dev SEPTEMBER 3, 1998 **Physician** 5:06 PM CHIEN-KING CHEN /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 24 Hrs. 8. Dete of Birth (Month, Pay, Year) OCT 15, 1920 If Under 1 Year 6 Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Months Deys 10 M 20 F CHINA 78 219-27-2495 Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MONTGOMERY POTOMAC 1 Yes 2□No MARYLAND Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10901 BARNWOOD LANE 20854 REPUBLIC OF CHINA Funeral 11 Meritel Stetus 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Yes 2 No 1 ☐ Never Merried 2 ☑ Merried 1 ☐ Yes 2 ☑ No Specify: Specify: ORIENTAL à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ARMY Elementery/Secondery (0-12) College (1-4or 5+) MILITARY (BRIGADIER GENERAL) REPUBLIC OF CHINA 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) 86 CHUN-JEN CHEN SHIH CHANG 2 19e. informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 10901 BARNWOOD LANE - POTOMAC, MARYLAND 20854 JEFFREY C. CHEN (SON) 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 Buriet 2 TCremetion 3 R 4 Donetion 5 Other (Specify) COMFORT CREMATORY 9/8/98 ALEXANDRIA, VIRGINIA 21. Signature of Funeral Ser 22. Name end Address of Fecility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852 23s. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate intervel Between Onset and Death immediate Cause (Final CEREBRAL VASCULAR ACCIDENT ONE WEEK disease or condition resulting in death) Due to (or es e consequence of) ASPIRATION PNEUMONIA ONE DAY Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco uas contributs to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown DIABETIC MELLITAS 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24e. Wes an eutopsy performed? HYPERTENSION ATRIAL FIBRILLATION 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury et Work? 28d. Describe how Injury occurred 1 (XNeture) 1 Yes 2 No

death certificate be executed P.O. Box 68760. signed by t Records. peed hes Division of Vital

**Funeral** 

Director

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or harve 23s or

High within 7 Hygiene.

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If Nem 27 is marked other any injury or other traumatic event.

**Physician** /Medical

Examine

Baltimore, Maryland 21215-0020

the Medical Examiner must be notifi

Examiner pue attending physician for use as the burial Physician/Medical by Completed Be Medical Certification: To this N or Attanding P safter death. I Director: After I After To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b

5 Pending investigation 2 Accident 3 ☐ Suicide 4 Homicide

6 Could not be

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Medical Examiner: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated.

1 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) end menner stated.

28t. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signeture end title of certifier

29e. Certifier (Check only one)

w 9

29d. Date signed (Month, Day, Year) Septenhe 3, 1988

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

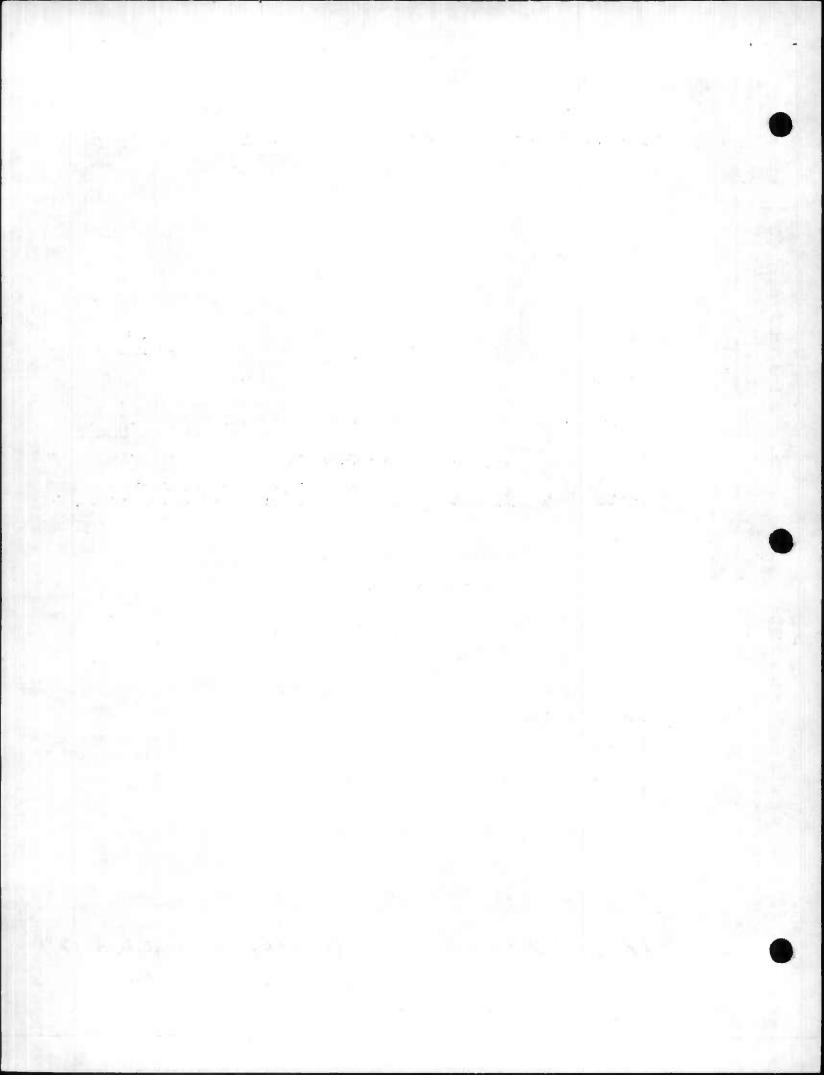
97-7 Medical center Dr. suit = 320. Ruclaille mis 20050 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture

State Registrar

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SEP 08

**DHMH 16 Rev 6/95** 



State of Maryland / Department of Health and Mental Hygiene |

_	-	1 Decedente Name (First Middle	f mod)		Certifica	ate of	Death		Reg. No.	Enn		100
Physic	ian	1. Decedent's Name (First, Middle		*				2. Date of Dee	Dev	Yeer	3. Tima o	
/Medi	cal	ELSIE GLA  4a. Facility Name (If not Institution,		ILDS			4b. City, Town, or I	SEPTEMB		998	11:1	5 PM
Exami	ner	107 B N. Summi		,			Gaithers			gomer	NV	
Funeral	П	5. Social Security Number	6. Sex 7. A	ga (In yrs. last b	irthday) If Und	der 1 Yaar s Days	If Undar 24 Hrs.			9	lace (State of	or Foraign
Director		219-64-5172	1□ M 2⊠ F	87	Yrs.	Days	Hours Mill.	8. Date of Birt (Month, De) April	22,1911	Vir	ginia	
9		Usual Residence of Decedent  10a. Stata  10b. County		10c. City. To	vn or Location					1/	0d. Inside C	itu Limite
after death with the Maryler or Neme 23a or 28a-f show tritiner must be notified at	ō	Maryland Montgo	mery		ersburg							2 □ No
r 28s	irec	10e. Street and Number			10f. 2	Zip Code			10g. Citizen of	What Coun	try?	
D wit	Funeral Director	107 B N. Summit	Avenue			2087	7		United	Stat	es	
r dea	ner	11. Merital Status	12. Was Decedent Armed Forces	Evar in U,S.	13. Was Dad	cedent of loecify Cub	Hispanic Orlgin? (S een, Mexican, Puert	pecify Yes or No- o Rican, atc.)	14. Rac	e - America	en Indian,	
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2 hox		15. Decedent's	Education		. Decedent'a Us	suai Occu	pation		16b. Kind of B	usiness/ind	lustry	
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permit. Pa Departmen Important: any Injury ance.		21. Signature of Funaral Service L		2	22. Nama	end Addr	ass of Facility	/12/98 L		ille.	, maryı	and
permit. Departr Imports any Inj ance		23a. Part1. Enter the disease, or or shock, or haart failure. List of	d/- 130	him	Murie	1 H.	Barber F	uneral H	lome			
Examiner	iner	disease or condition resulting in death)	a. 14/2/0	Dua to (or es a	consequence o		ream	, 10 ,	NV-C		(0 W	soll
tificate be executed g physician and es the buriel-transit	il Examiner	Sequantielly list conditions, if eny, leading to Immadiete cause. Enter Underlying Cause (Disease or injury that initiated evants		Dua to (or as a	consequence o	f):				i		
ertificate I Jing physice es the t	Medical	that initiated evants resulting in death) Last	d	Dua to (or as a	consequance of	f):						
thet the deeth cert ed by the ettendin detached for use	Physician/N									İ		
y the diched	ysi	Pert II. Other significant condition	contributing to death t	out not resulting	In the underlying	g cause gi	ven in Part I.		obacco use co			
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5 00	To	axaminar?	Hospital: 1 ☐ Inpati	ent 2 ER/O	utpatient 3 1	DOA Ot	hon	ome 5 Pasid		er (Specify	1)	
ng Ph ter thi neral		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Inju	ury 28b.	Tima of Injury	28c. Inju	ry at	28d. Describe h	ow injury occur	red		
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or Attending I s after death. If Director: After of in by the funer	Certification:	3 Suicida 6 Could no 4 Homicide determin	ed 288. Place of in	jury - At home, f tc. <i>(Specify)</i>	arm, atreet, fact	ory, office		28f. Location (5 City or Tow		per or Rure	/ Route Nun	iber,
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5		> XXX ?	Son	0	mo	T	0580	po	al	9/9	8	
2		30. Name and address of person w	no completed cause of	deeth (Item 23e)	(Type, Print)	,0			,	1111	0	
		TOHNG LO	DWELL	an,	29010	DLN	27-RD	. OU	P34	MD	300	337
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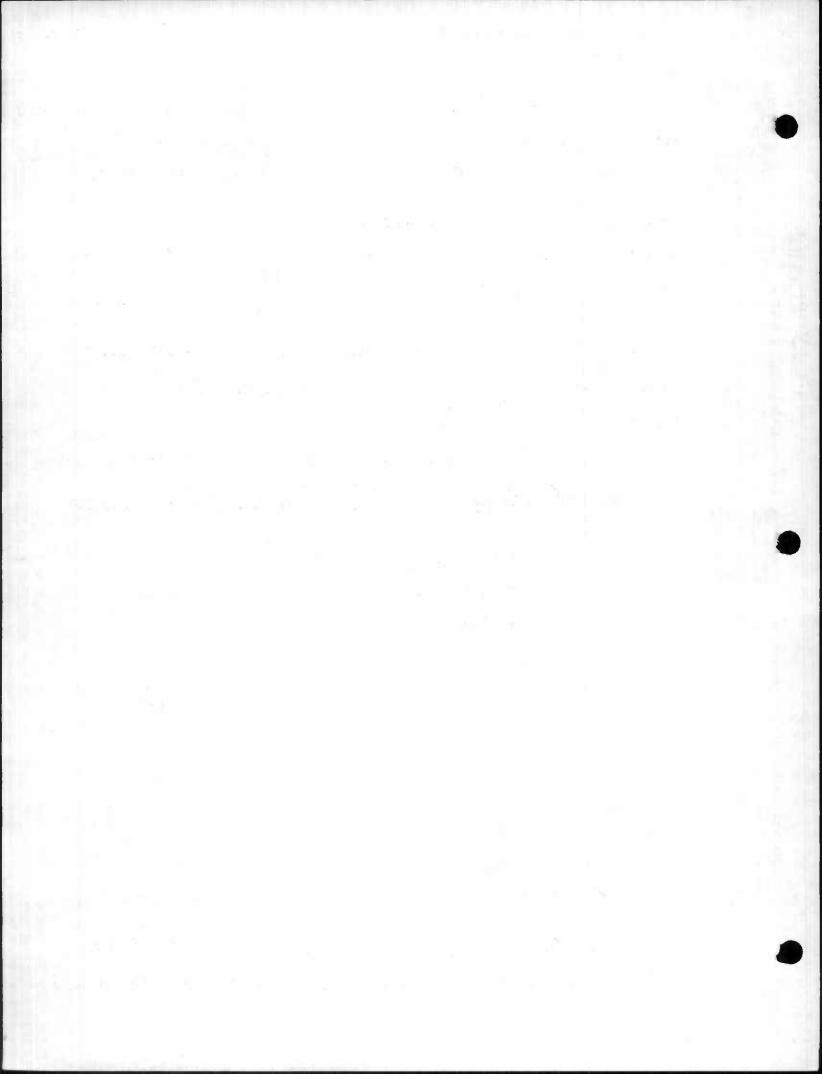
State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** SEPTEMBER 3, 1998 Collins Ricky Lee 11:18 AM /Medical 4b. City, Town, or Location of Deeth 4e. Fecllity Neme (If not institution, give street end number) 4c. County of Deeth Examiner | Lallings | Hunder 24 Hrs. | 8. Date of Birth (Month, Pay, ) | Aug. 10, Prince George's Doctors Community Hospital Lanham 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1⊠ M 2□ F Yrs. 39 1959 Maryland 220-56-2386 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic average. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Directo Maryland Prince George's Mount Rainier 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3504 Shepherd Street 20712 United States Funeral 12. Was Decedent Ever In U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☑ No It Yes, Give Year or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: 3 □ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Merchandise Receiver Retail Dept. Store 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Collins Elizabeth Gibson David 19a. Informent's Name/Relationship (Type, Print) (domestic | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Charles S. Stewart partner) Same as 10 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 MCremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 9-5-98 Beltsville, Maryland Chesapeake Crematory 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Rapp Funeral Services, P. A. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. 933 Gist Avenue, Silver Spring, MD 20910 Approximete Intervel Betw **Physician** Immediate Cause (Final disease or condition resulting in death) 14 days /Medical **Examiner** Examiner The law requires that the death certificete be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es a consequence ot) Physician/Medicai Due to (or es e consequence ot) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings eveilable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? hes 2 DINO certificate 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ impatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) 27. Menner et Deeth 1 Neturel 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation efter death. Diractor: Aft 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, tectory, offica building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours e vithin 24 hours e vithin Euneral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es stated. 29a. Certifier Medicai (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) BRANCH AVENUE, CUNTON, MO 31. Dete tiled (Month, Dey, Year) State 0 8 1998 Registrar

Box 68760

P.0.

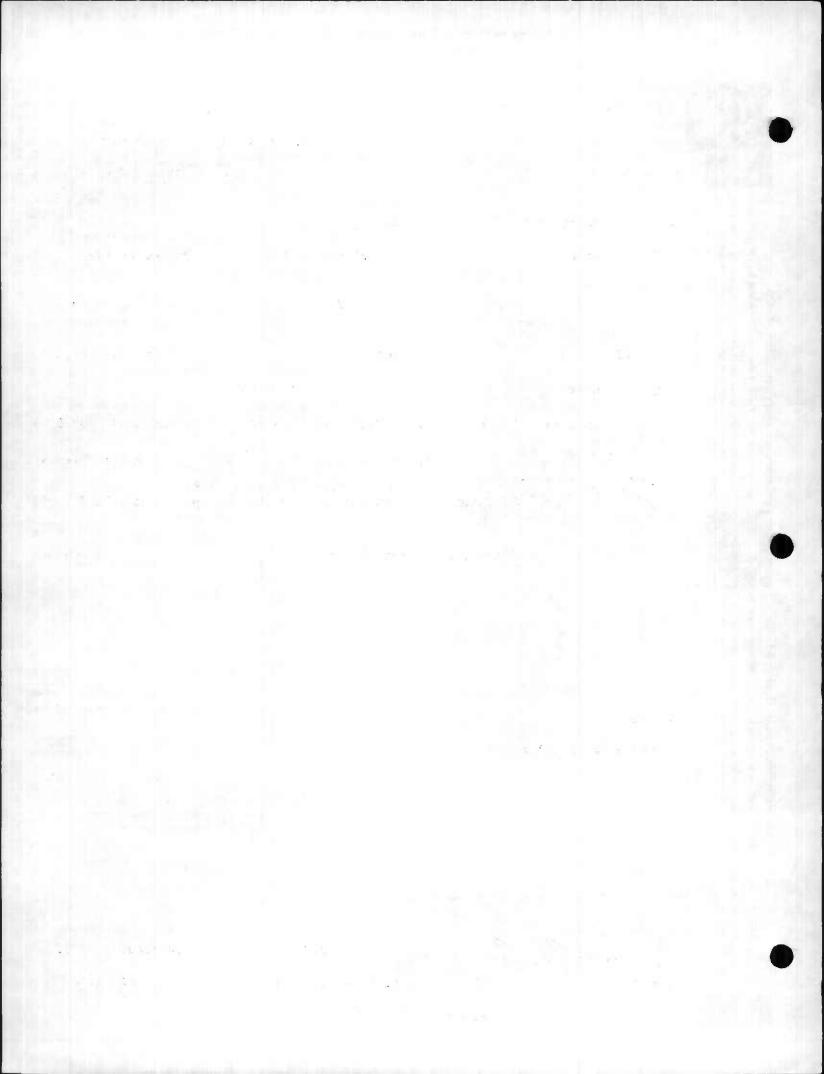
Division of Vital Records,



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			Cer	uncate of	Dealli		Reg. No.			
		ck				Month	Dey	Year 998	3. Time of Death 12:50 PM	
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		10c. City, To	c. City, Town or Location 10d. Ins							
									1 ☐ Yes 2 ☐ No	
2	omery	SIIVe.	r sp	7			10g. Citizen of	Whet Count		
					Spring		United	States	5	
11. Marital Status	12. Wes Decede	ent Ever In U,S.	13. V			(Specify Yes or N	lo- 14. Rac			
	ried 1 ☐ Yes 2. If Yes, Give	No No				erto Hican, etc.)		v	ite	
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19e. Informent's Name/Reletions	hip (Type, Print)	19	b. Mailin	g Address (Stree	et end Number or	Rurel Route Num	ber, City or Town	, Stete, Zip	Code)	
R. Bruce Craddo	ck (son)	1.	201	Goth Lar	ne, Silve	er Sprin	g, Maryl	and :	20905	
20e. Method of Disposition	0 🗆 🗆	comet	of Dispos	sition (Neme of natory or other pl	ece)	Dete	20c. Location	- City or Tov	wn, Stete	
			peak	e Cremat	ory	9-8-98	Beltsv	ille,	Maryland	
21. Signature of Fusional Service	Δ									
Kull	L. Kas	bo						arvla:	nd 20910	
23a. Pert1. Enter the disease, or	complications that cau	sed the deeth. Do							Approximete Intervel Between	
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Part II. Other significent condition	ons contributing to deat	h but not resulting	In the un	iderlying cause g	iven in Pert I.	23b. DI	d tobecco use co	ontribute to	the cause of death?	
Anemia						10	Yes 2 No	3 Prob	ably 🐠 Unknown	
Bleeding from	Colostomy					24e. Wa	is en eutopsy formed?	con	re eutopsy findings illeble prior to npletion of cause deeth?	
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1 Yes 2X No	Hospital: 1 ☐ Inp	patient 2 ER/C	Outpatien	3□ DOA O	ther: 4 Nursing	Home 5 TXRe	sidenca 6 🗆 Otl	ner (Specify	)	
2 ☐ Accident investi	ng (Month, getion		. Time of injury			28d. Describ	e how injury occu	rred		
	ined 200. Pleca of	Injury - At home, , etc. (Specify)	ferm, stre	et, fectory, office				ber or Rure	Roufe Number,	
	Examiner: On the besi	s of examinetion e								
30. Name end eddress of person	who completed cause			D35	5996		Septemb	er 7,	1998	
			1 Pa	rk Drive	e, #210,	Silver	Spring,	MD 2	0902	
		istrer's Signature	4	1	,					
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Service Liberage Cause. Enter Underlying Cause (Disease or injury that Inhiede avents resulting in deeth) Last  Part II. Other significent conditions contributing to deat Anemia  Bleeding from Colostomy  25. Wee case referred to medical examiner? 1 Yes 20 No 27. Manner of Deeth 1 No No No No No No No No No No No No No	Elizabeth F. Craddock  4e Fecility Neme (If not institution, give street end number)  1201 Goth Lane  5. Social Security Number 227–18–0873  Usual Residence of Decedent 10e. State 10b. County 80  10e. Street end Number 1201 Goth Lane  11. Maryland Montgomery Silve 10e. Street end Number 1201 Goth Lane  11. Marital Status 1	1. Decedent's Neme (First, Middle, Lest)   Elizabeth F. Craddock	Second Security Number   17	Elizabeth F. Craddock  4e Festip Name (If not institution, give street end number)  1201 Goth Lane  5. Social Security Number  5. Social Security Number  6. Social Security Number  100. State  100. County  Maryland  Montgomery  100. City, Town or Location  Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Silver Spring  100. Spring  100. Silver Spring  100. Silver Spring  100. Spring  100. Silver Spring  100. Spring  100. Silver Spring  100. Spring  100. Spring  100. Spring  100. Spring  100. Spring  100. Spring  100. Spring  100. Spring  100. Spring  100. Spring  100. Spring  100. Spring  100. 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Craddock   2. Date of Death   Day   Year   September 6, 1984   Non-tension of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death   Date of Death	

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 6:40 AM SEPTEMBER 6 1998 Gary Lee Carder /Medical 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Sacred Heart Hospital Cumberland Allegany If Under 1 Year If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1□ M 2□ F Days Months Yrs. Director 218 60 0554 46 2/8/52 MD Usual Residence of Decadent the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits Hygiene. uther than "natural", or items 23a or 28a-f show ent, the Medical Evant net must be notified at 10b. County 1XX es 2 □ No Allegany MD Ellerslie Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? death with 10117 Hummingbird Street 21529 LISA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritai Status hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2000 White altimore, Maryland 21215-0020 Specify: Specify: ò 3 □ Widowed 4 □ Divorced Completed permit. Pages 1 and 2 should be filed within 72 h Deperment of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natuu any injury or other traumatic event, tra Medical pages. 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert C. Carder Elsie E. Johnson 0 19a. informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan E. Carder, Spouse 10117 Hummingbird Street, Ellerslie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Altoona Area Crematory 9/7/98 4 ☐ Donation 5 ☐ Other (Specify) Altoona, PA 21. Signature of Juneral Service Licenses 22. Name and Address of Facility Harvey H. Zeigler Funeral Home, Hyndman, PA To not enter the mode of dying, such as cardiac or respiratory errest, Approximate interval Between Onset and Death **Physician** 1001 /Medical immediate Ceuse (Final arcinoma Years disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner that the death certificate be executed physician and s the burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequenca of): Box 68760 Physician/Medical Due to (or as a consequence of): ettanding p signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 0 1 Yes 2 No 3 Probably 4 Unknown 9 by Records, The law requires 24b. Were eutopsy findings available prior to completion of cause of death? been si 24a. Wes en eutopsy performed? Completed is cartificate has to director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this cartifica etchy filled in by the funeral director, f 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Impatient 2 □ ER/Outpatient 3 □ DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, efc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of applies 29c. License number SEPTEMBER 30. Name and address of person wh leted cause of death (itel) 26) (Type, Print) sofon homas 31. Dete filed (Month, Dey, Year) SEP 0 8 1998 32. Registrar's Signature State

Registrar

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

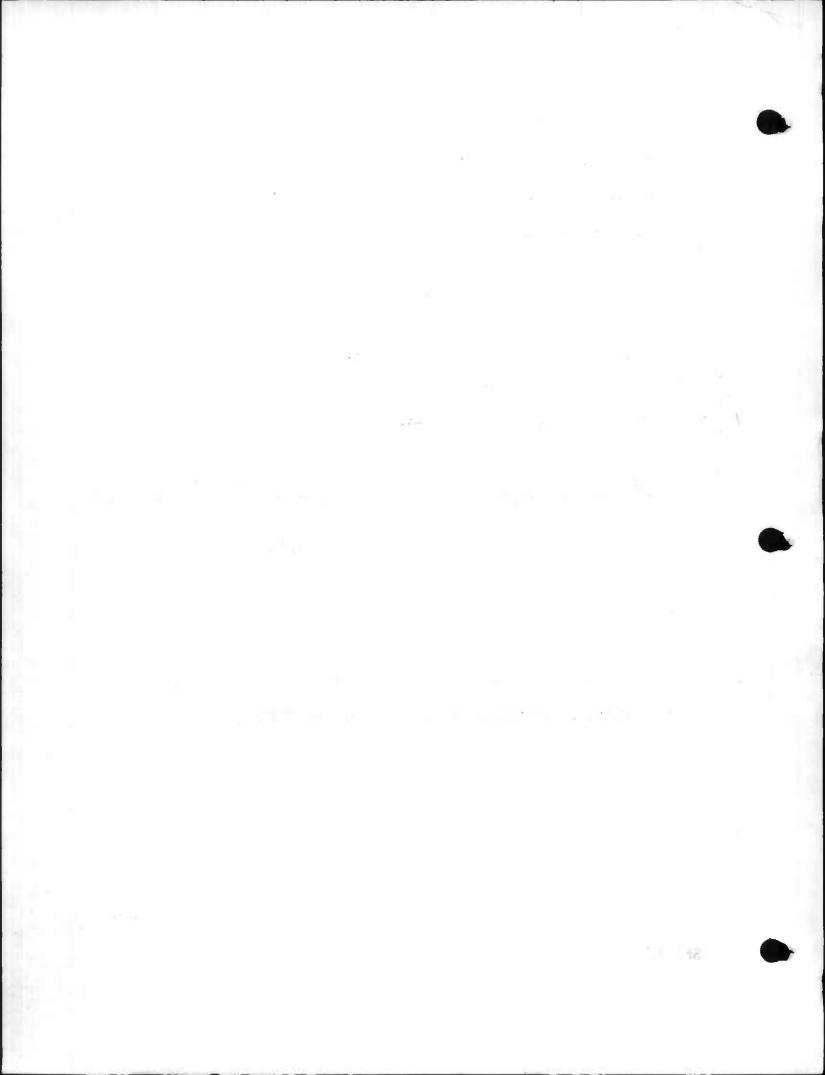
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permit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It tiem 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE 0	F MARYLAND	/ DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENE
		EDTICIOATE	OF DEAT			

	1 - FOR STATE REGISTRAR	ATE OF MARYLA	ND / DEPARTM			MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			IME OF DEAT	н
	LILLIAN A. CAT	INA				SEPT 2	. 199	YEAR	:02	D M
	4. SOCIAL SECURITY NUMBER 5. SE	8. AGE (Ir		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		. BIRTHPLAC	E (State or Fo	reign
	220 0, 0312	M <sup>2</sup> 🖁 <sup>F</sup> 100	) YRS.	NTHS DAYS	HOURS MIN.	JUNE 29, 18	398 M	Country)	AND	
œ	9e. FACILITY NAME (If not institution, give street and				R LOCATION OF DI	EATH	9c. COUNT	Y OF DEATH		
DIRECTOR	ALLEGANY COUNTY	NURSING	HOME	CUMB	ERLAND		ALLI	EGANY	<u></u>	
H	10e. STATE 10b. COUNTY		10c. CITY, T	OWN OR LOCAT	ION			t0d.	INSIDE CITY	
	MARYLAND ALLEG	ANY	CUM	BERLA				1 [	YES 2	NO
FUNERAL	Charles of the second	m pomor			ZIP CODE			N OF WHAT	COUNTRY?	
2	13204 PERSHING S	AS DECEDENT EVER IN			21502	NIC ORIGIN? (Specify Yes		S.A.	merican India	
	1 Never Merried 2 Merried FC	PRCES? 1 YES	2 X NO	If yes, sp		in, Puerto Rican, atc.)	W 10-	Black, Whi	te, elc.	m,
р ву	3 🔀 Widowed 4 🗌 Divorced "					,,		ороспу	WHITI	E
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade complete	ed)	(Give kind of work life. Do NOT use re	done during mo	N st of working	16b. KIND OF BUS	SINESS/INDUS	STRY		
PLE	Elementary/Secondary (0-12) Colle UNKNOWN	ge (1-4 or 5+)	HOMEM			HOME				- 1
NO.	17. FATHER'S NAME (First, Middle, Last)		ПОПЕП	MULL	18. MOTHER'S NA	ME (First, Middle, Maiden	Surname)			
BE C	UNKNOWN	PELICAN			UNKNO	NWN				
2	19a. INFORMANT'S NAME (Type/Print)		195 MAILINO AD	ORESS (Street e	nd Number or Rural i	Route Number, City or Town	n, State, Zip C	ode)		
-	SISIER M. ANGELINA CAITI		6)+ N.	CENTR	E STREET	CUMBERLA	ND, MI	215		
	20e. METHOD OF DISPOSITION  1	m State ceme	LACE AND DATE OF C	place)			CATION — CI			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	150	NSET MEN	T-10	D ADDRESS OF FA	9/5/98 CUI	MBERL	AND,	_MD_	-
	March & You	church	į	UPCHU	JRCH FU	NERAL HO	ME, P	.A.		
	23. PART i. Enter the diseases, or compile	cations that caused	the deeth. Do not	enter the mo	GREENE	ST., CUMI	BERLA	ND, M	D 215	
	shock, or heart failure. List on iMMEDIATE CAUSE (Final	iy one ceuse on ee	ch line.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		atory arres		interval Ba	tween
		DUE TO (OR AS A	Legen	4 6	KEKI	5		j		KI
	touring in account	DUE TO (OR AS A	CONSEQUENCE OF):		1301.3				10 1	-5
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ATI	if sny, leeding to immediate cause. Enter UNDERLYING	DUE TO JOH AS A C	CONSEQUENCE OF):							1
IFIC	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):					-		
CERTIFICATION	resulting in death) LAST									
AL C	PART ii. Other significant conditions contri	ributing to death bu	t not resulting in t	he underlying	csuse given in	Pert i. 24s. WAS AN	AUTOPSY	24b. WERI	E AUTOPSY FIR	MOINGS
CA	PERIPHERIN A					PERFOR  1 TYES 2	MED?	COM	LABLE PRIOR T	10
PHYSICIAN: MEDIC							Z) NO		EATH?	10
ž	DID TOBACCO USE CON	TRIBUTE TO	CAUSE OF I	DEATH Y	ES NO	D ☑				
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	PITAL:	100	26. PL THER:	ACE OF DEATH (Ch	eck only one)				
IXS	1 YES 2 NO 1 In	patient 2 - ER/Oulpa	ient 3 DOA 4	9 Nursing Hom		8 Other (Specify)				
	1 Netural 5 Pending	(Month, Day, Year)	28b. TIME O	WO	RK?	28d. DESCRIBE HOW IN	JURY OCCU	RED		
BY	2 Accident Investigation 3 Suicide 8 Could not be	Ba. PLACE OF INJURY -	- At home, farm, stree		ES 2 NO	281. LOCATION (Street a	nd Number or	Bural Brusta I	Mumber	-
COMPLETED	4 Homicide 8 Could not be	building, atc. (Specif	d.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, State)	no reamber or	nurer noore r	rumber,	- 1
PLE	29a. CERTIFIER (Check only	the beat of my knowle	dge, death occurred a	t the lime, data	and pleca, and due	to the cause(e) and men	ner ee stated			
OM	one) 2 MEDICAL EXAMINER: On the	e beele of examination	and/or investigation, is	n my opinion, d	ath occured at the	time, data end place, end	due to the	ceuse(e) and	menner as at	ated.
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUN	ABER	29d. DATE S	SIGNED (Mont	th, Day, Year)	
TO B	18/ Jana				D-14	865	SET	PT.	3, 199	189
	30. NAME AND ADDRESS OF PERSON WHO COMP				ODTAT	AVE CIN	י משמו	TAID	MD 2	1 500
	ROBUSTIANO J. BZ	REGISTRAR'S SIGNAT		O HEN	OKTAL A	AVE., CUI	IDEKA	, מאת	MD Z	1 504
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State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** - 2-Francis Barton Hillocks CUNNINGHAM 2:45 .M. September 7, 1998 /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6302 Bradford Court Frederick Frederick Hours Min. 8. Data of Birth (Month, Day, Year)
March 4, 19 5. Social Security Number If Undar 1 Yaar 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign
Country) **Funeral** Months 1X M 2□ F Days 69 Yrs. 130-42-2394 Scotland 1929 Director Usual Residence of Deceden with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6302 Bradford Court 21701 items 23a U.S.A. Funeral death 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, atc. 11. Maritai Status Peges 1 and 2 should be filed within 72 hours efter nated of Health and Mental Hygiene.
anta if item 27 is marked other than "natural, or item ury or other traumatic event, I'm Modical Estation ury or other traumatic event, I'm Modical Estation. 1 Never Married 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Parts Manufacturer's Elementery/Secondary (0-12) College (1-4or 5+) Machinist Company 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be CUNNINGHAM Charles Mary HILLOCKS 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 6302 Bradford Court, Frederick, MD 21701 Bonnie L. Cunningham, Wife 20a. Method of Disposition
1 ☐ Buriai 2 ☐ Cramation 3 ☐ Removal from State 20b. Place of Disposition (Name of cometery, cremetory or other place) 20c. Location - City or Town, State Depertment Important: If any injury o 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory, Sept. 9,1998 Smithsburg, Maryland 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 21. Signature of Funaral Service Licanses M00703 106 East Church Street, Frederick, MD 21701 23a. Part1. Entar the disease, or complications that used the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause and hine. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medicai year Examiner Examiner To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours effer death.

To the Fueral Director: After this certificate hes been signed by the ettending physician and completely filled in by the ituneat director, page 2 should be detected for use as the burial-transit completely filled in by the stuneat director, page 2 should be detecthed for use as the burial-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 15€Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Piece of Death (Check only one) Othar: 4 Nursing Home 5 esidence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28e. Placa of injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Descritiving Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titla of certifier D41619 September 8, 1998 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Michael Lerner, M.D., 15 East Frederick Street, Walkersville, MD 21793 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

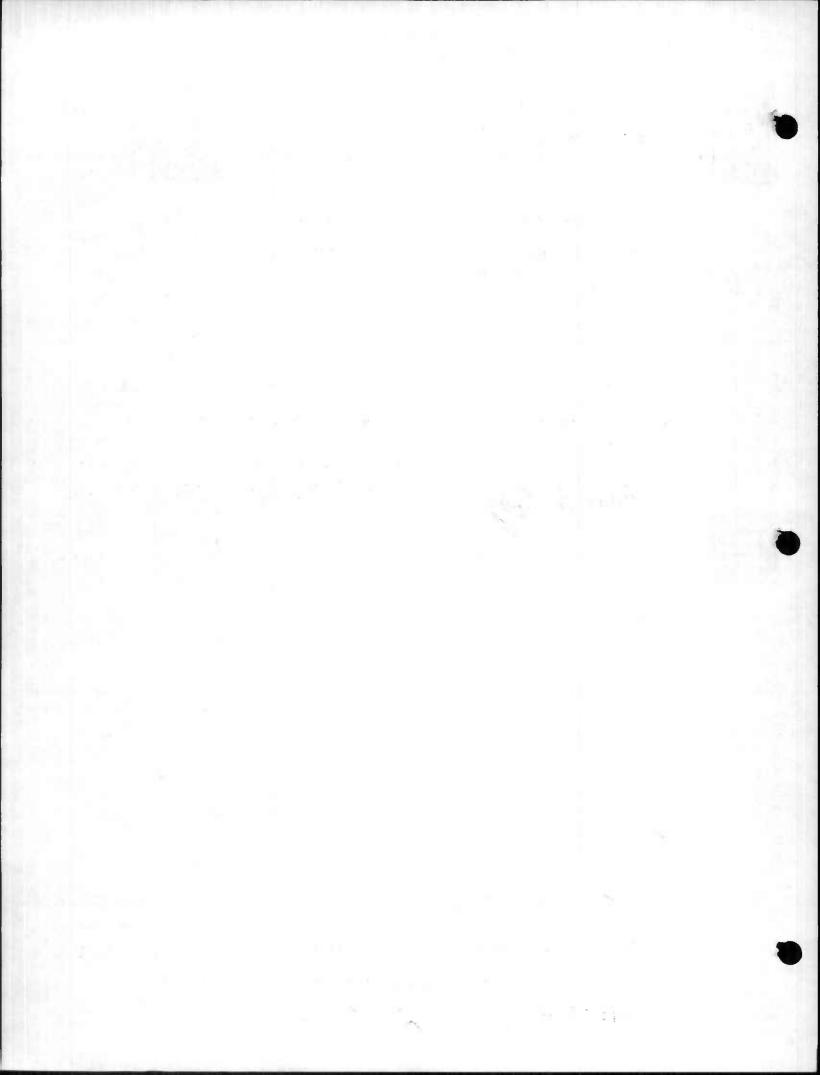
South

**DHMH 16 Rev 6/95** 

Registrar

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SEP 09



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** SEPTEMBER 10,1998 THOMAS JARRETT CLARK 2:55 AM /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER LAPLATA CHARLES | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | MARCH 3,1920 6. Sex 1 Ø M 2 ☐ F 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) MARYLAND 217-30-0560 78 Yrs Director Usual Residence of Decedent 72 hours efter death with the Maryland 10b. County 10c. City, Town or Location 10d. inside City Limits traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director MARYLAND CHARLES NEWBURG 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? items 23a 12580 ROCKPOINT ROAD Funeral 20664 UNITED STATES 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1944. 5 1 ☐ Yes 2 No by Specify 3 Widowed 4 Divorced "natural", 1946 BLACK Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry be filed within 7. Ial Hygiena. Elementary/Secondery (0-12) College (1-4or 5+) 3RD. GRADE TRUCK DRIVER STATE HIGHWAY ADMIN. Ith and Mental Hyr 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be JOHN LINDSAY CLARK Peges 1 and 2 should the sent of Health and Ment MARY REBECCA CARROLL CLARK 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once. THOMAS C. CLARK / SON P.O. BOX 273 NEWBURG, MARYLAND 20664 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1XDBuriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) HOLY GHOST CHURCH CEM. 9/15/98 ISSUE, MARYLAND 21. Shandure of Funeral Service Ligensee 22. Name and Address of Facility
THORNTON FUNERAL HOME, P.A. Join THORNTON JOHNSON M00583 3439 LIVINGSTON ROAD, INDIAN HEAD, MD DIA C. 20640 23e. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting In death) Examiner Due to (or as a consequence of) The lew requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last end Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical Due to (or as a consequence of): signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | TNo 3 | Probably 4 | Unknown Division of Vital Records. Completed by 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? peen has After this certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Was case referred to medical exeminer? 26 Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 No 1 ☐ Yes 1 ☐ Inpatient 2 DER/Outpetient 3 ☐ DOA funeral Certification: 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No spital or Attendi lours effer death. Neral Director: A filled in by the fr death. 2 Accident 3 Sulcide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours e To the Funeral C completely filled Hospital 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

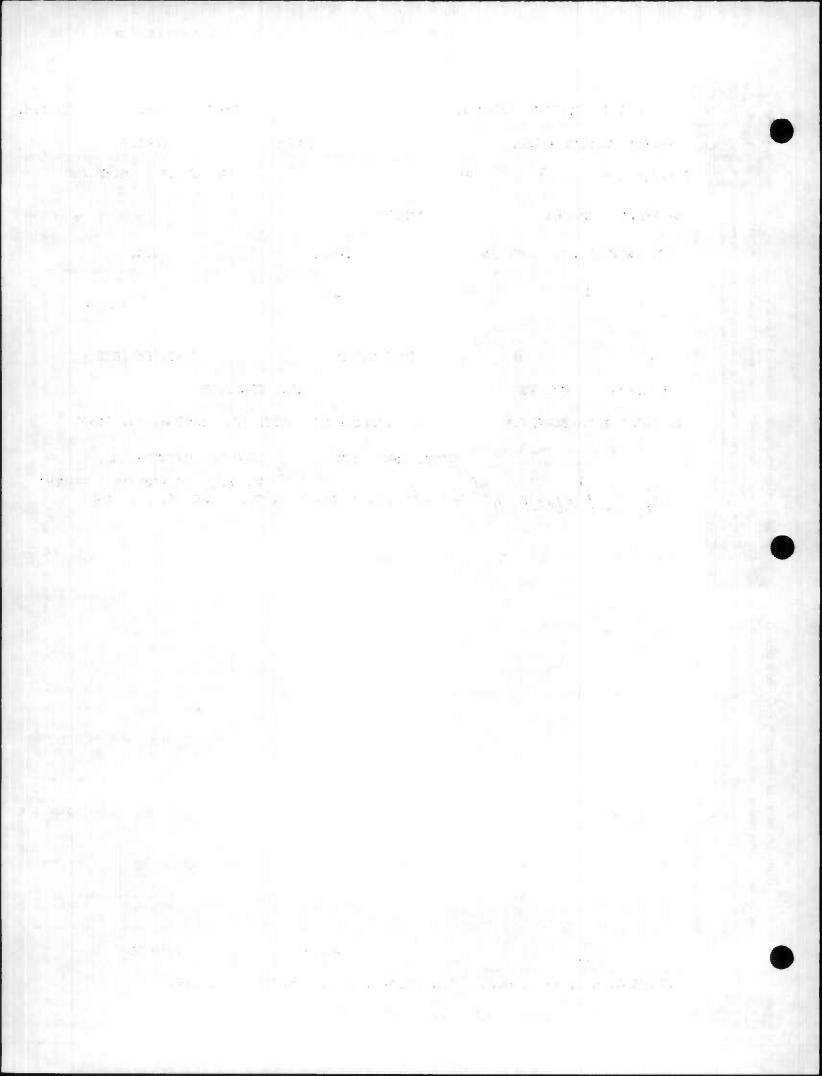
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medicai 29a, Certifier 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Dey, Year) D-08370 30. Neme and address of person who completed cause of death (item 23e) (Type, Print) PAUL PRITCHETT M.D. 118 LAGRANGE AVENUE P.O. BOX 1317 LAPLATA MD. 20646 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar 1

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) **Physician** 7, 1998 ARTHUR NEAVITT CHEEZUM SEPT. 7:35 A.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** TALBOT HOSPICE HOUSE EASTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** M 20 F Days Hours Min Yrs. 81 APR. 22,1917 MARYLAND **Director** 215-26-4328 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiana.
Important: If item 27 is merked other than "natural", or items 23s or 28s-f show any injury or other traumetic event, the Westral Examples must be notified at each. with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□ No TALBOT MARYLAND EASTON Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 201 FEDERAL ST., APT. 28 21601 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indien 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 TNo Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 FEED MIXER POULTRY FEED 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be COLLISON WTT.T.TAM CHEEZIM ADA 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) C. LUCILLE CHEEZUM/WIFE 201 FEDERAL ST., APT. 28, EASTON, MD. 21601 20b Piece of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State CHES. CREM. CTR 9-8-98 CHESTER, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM 21. Signature of Funeral Service Licensee 200 S. HARRISON ST., EASTON, MD. 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediete Cause (Final disease or condition resulting in death) /Medical 10-20 Yrs Emphy Sema
Due to (or as a consequence of): **Examiner** Examiner physician and s the burial-trans Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest Due to (or es a consequence of): certificeta be axecu P.O. Box 68760, Physician/Medical Due to (or as a consequence of): as t - PSP 23b. Did tobacco usa contributa to the cause of death? ed by the detached Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records, by 24b. Were eutopsy findings evailable prior to 24a. Was en eutopsy performed? Completed completion of cause of death? Tha law page 2 s certificete has 1 Yes 2 NO 1 Yes 2 No Physicien: Be 25. Was cese referred to medicel 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Sother (Specify) HOSPICE 1 Yes 2 No 2 After this the funerel 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Deeth 28c. Injury et Work? Certification: Hospital or Attending 1 Matural 5 Pending investigation deeth. 1 Yes 2 No 2 Accident after deeth 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 | Homicide 24 hours 11 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) end manner es steted. 29a. Certifier To the Hosp within 24 hou To the Fune completaly fi Medical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) and manner stated. (Check only one) 29b. Signeture and title of continu 29c. License number 29d. Date signed (Month, Dey, Year) 9-8-1998 D44749 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) PETER L. WHITESELL, M.D. 508 IDLEWILD AVE. EASTON, MD. 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State books SEP - 9 1998 Registrar

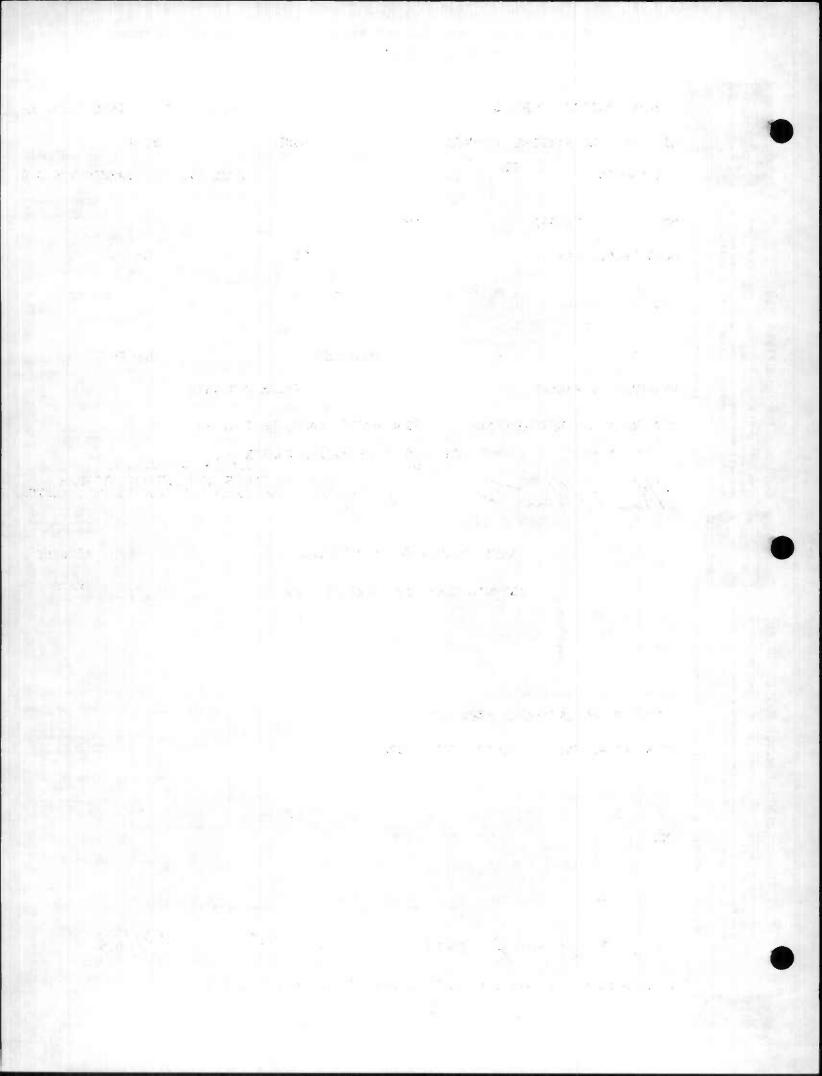
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State of Maryland / Department of Health and Mental Hygiene 9

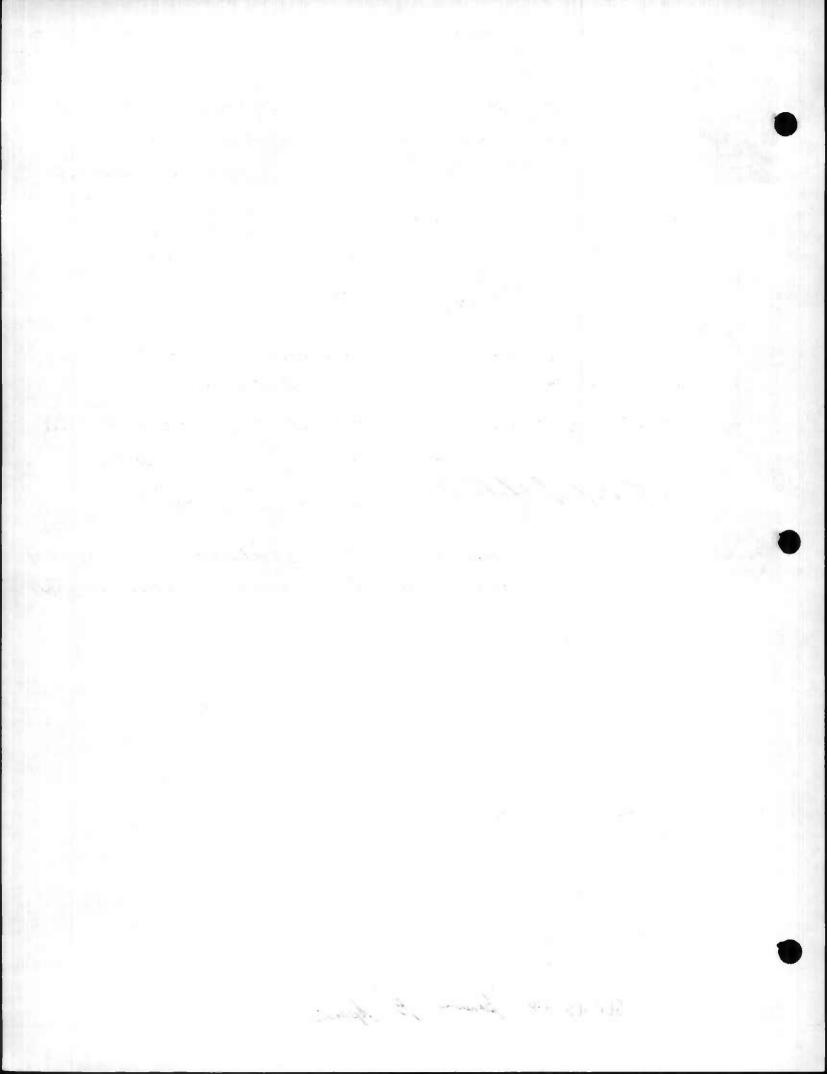
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	Funeral Director		5. Social Security Number 6. S 214-46-6554	ex □ M 2KXF	7. Aga (In yrs	: last birthday) Yrs.	Months Da		Min.	8. Date of I (Month, SEPT	Day, Yas	906		ace (State or Foreign try) INGTON D.C	
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	r 28a	irec	10e. Street and Number				10f. Zip Cod	e			10g. (	Citizen ot	What Coun	try?	
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Ħ	9 9 7 5	4 Donation 5 Other (Specify)  L.L.C.  21. Sensor of Funeral Service Licenses  22. Nama and Address of Facility FELLOWS, HELFENBEIN, 8													
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	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai C	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	lner: On the I	e best ot my kr basis ot examin	nowledge, death nation and/or in	h occurred at the	e time, date i	and place, eath occur	and due to t	he cause ne, date	e(s) end m and place	nanner as s	tated. the cause(s)	
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	¥ ¥ 5 8		I wan Har	oud y	M	)		708				9/7	198		
			30. Name and address of person who WILLIAM $\mbox{H.}$ WOOD,					EASTON	, MD	21601					

State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day William Conger September 7, 1998 2155 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Kent & Queen Anne's County Hospital Inc. Chestertown If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Month, Day, Year)
November 10, 1922Norristown, PA 10XM 20 F Months Days Director 211-22-9479 Usuel Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28±f show any injury or other traumatic event, the Mexical Examina. 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 1 No 2 No Director Maryland Kent. Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 309 Heron Point 21620 U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11 Marital Status 1 M Yes 2 No If Yes, Give Year or Dates: 1941-1945 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No þ Specify: White 3 Widowed 4 Divorced Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Electric 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John de Peyster Conger Katherine Hare 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. S. McCoy/Daughter 400 Indiantown Farm Road, Centreville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Phoenix Cemetery 9/14/98 Phoenix, NY 21. Signeture of Funeral Servica Licansee, 22. Name end Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown MD 21620 tenter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset end Death **Physician** Clueire Muleutien Pulsury Sieur /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner attending physician end for use es the buriel-tran Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed 24a. Was an eutopsy certificate 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes No Other: 4 Nursing Home 5 Residence 8 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Hospital or Attanding P
 24 hours efter death.
 Funeral Director: After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 - Homicide within 24 hours e To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier Medicai To the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0-138-24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John C. Seymour 122 Speer Road Chestertown, MD 21620 32. Registrer's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth Dev **Physician** 4c. County of Deeth 4b. City, Town, or Location of Deeth 9:30PM TDA DTAMOND /Medical 4e Fecility Neme (If not institution, give street end number) Examiner **Rockville** Montgomery Hebrew Home of Greater Washington 7. Age (In yrs. lest birthday) If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dev. Yeer) **Funeral** Deys Hours 1 M 2 KF 92 Yrs. 214 48 9214 **Director** Sept 18, 1905 Balt. MD Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or itams 23a or 28a-f ahow Examiner must be notified at XXYes 2 No Directo Rockville Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 22052 USA 6160 Montrose Rd Pages 1 and 2 should be filed within 72 hours after death a near of Health and Mental Hygiene. Init: If them 27 is marked other then "natural", or Itama 23, ITY or other traumatic event, it is final or mainty. Funeral 14. Rece - American Indien, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bieck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify. þ White 3 XWidowed 4 ☐ Divorcad Completed 7 is marked other than "natur traumatic evant, the Medical 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) Coilege (1-4or 5+) Self Employed Retail Merchant 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Rose Mildred Tucker Leib Hershall Kushner 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Alexandria, Va. 22314 947 N. Pitt St, Louis Diamond Son 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 X Bernoval from State 4 Donetton 5 Dother (Specify) 9-13-1998 Falls Church, VA King David Memorial Gardens 21. Signature of Funeral Service Lice 22. Neme end Address of Fecility Danzansky-Goldberg Memorial Chapels, Inc. ease of amplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximations that caused the deeth. Approximete Intervei Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) CO(PD Due to (or es e consequence of): Physician/Medical Examiner STEOPOLOSIS and. Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequenca of) attending physician a for use as the burialthet Initiated events resulting in deeth) Last Due to (or es e consequence of): 58 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. signed by the a 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HEART by 24b. Were autopsy findings eveilebie prior to 24a. Wes an eutopsy performed? Completed completion of cause of deeth? i certificate has b 1 Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitai: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA funeral 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation Neturel 1 Tyes 2 No Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 24 hours after of Funeral Direct pletely filled in by 4 - Homicide 156 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) and manner es steted.
2 Medicat Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end placa, and due to the ceuse(s) end manner steted. 29a, Certifier edical (Check only one) To the To the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 05885 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) ROCKVILLE MONTROSE RD 6121 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State

Registrar

SEP 1 1 1998

the Maryland

with

the death certificate to emecut

Attending Physician:

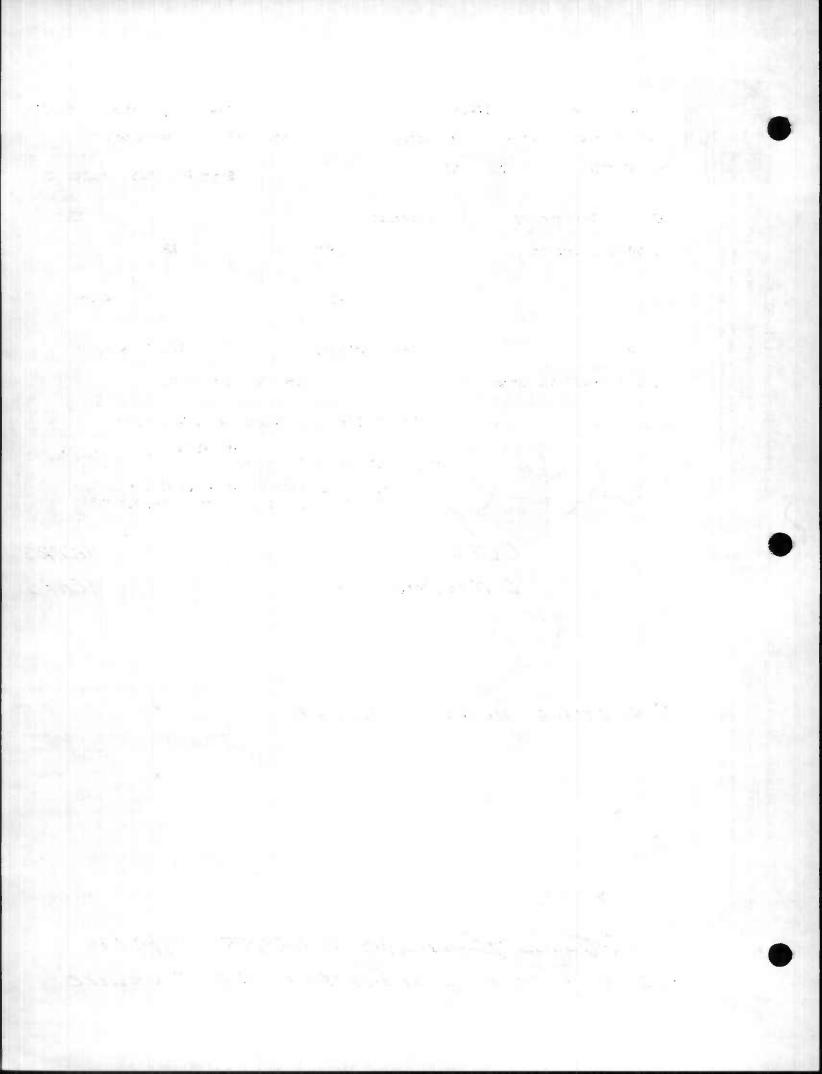
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death.

Division of Vital Records, P.O. Box 68760,



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth SEPTEMBER 5,1998 **Physician** DOVE LUCY Ι. 7:30 AM /Medical 4a Fecility Name (If not institution, give street end number)
MONTGOMERY GENERAL HOSPITAL 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner OLNEY MONTGOMERY Hours Min. 8. Date of Birth (Month, Day, Year)

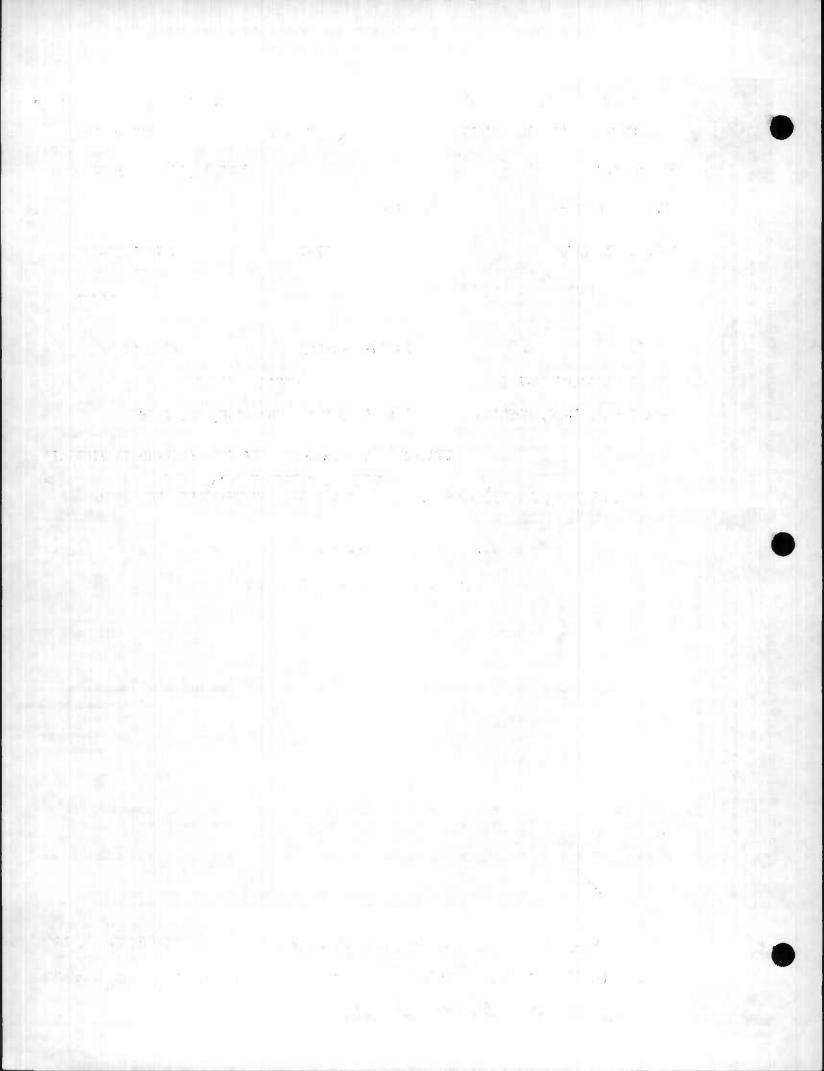
JUNE 19,1929 If Under 1 Year Months Days 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Months MARYLAND 1 M 2 XF 215 26 3402 69 Director Usual Residenca of Decedent with the Merylend 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. Count "natural", or items 23a or 28a-f show MD. CARROLL WOODBINE 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5906 DAVIS ROAD 21797 UNITED STATES permit. Pages 1 end 2 should be filed within 72 hours efter death 1 Department of Health end Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Mod Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Yeer or Dates: 14. Reca - American Indian, 11. Maritai Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) O<sup>College (1-4or 5+)</sup> Elementary/Secondary (0-12) BAKERY MANAGER FOOD STORE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) HARRY RANDOLPH SAVAGE OSSIE POOLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) THORNTON S. DOVE, HUSBAND 5906 DAVIS ROAD, WOODBINE, MD. 21797 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State METROPOLITAN CREMATORY 9/6/98 ALEXANDRIA, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MURTEL HOME BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirelory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediete Cause (Final disease or condition resulting In death) /Medical ACUTE RESPIRATORY 10 241 Examine Due to (or as a consequence of): Examiner TOLY CATUE MICH physician end the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed s certificate hes b 1 Yes 2D No 1 Yes 2 No director, or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Nopatient 2 ER/Outpetient 3 DOA Certification: To this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred After 5 Pending Investigation 1 Natural death. 1 ☐ Yes 2 ☐ No ofter death Director: A 2 Accident 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Vithin 24 hours oft To the Funeral Discompletely filled in 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred et the time, date and pleca, end due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. To the F 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number Lagar HI-5, 1998 SEPTEMBER 10698 E 214 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) EDLARH, LETTH, M.D. 986168919 19 AX, S. (1)88 58819 198. 20902

State Registrar 31. Date filed (Month, Dey, Year)

SEP 0 8 1998

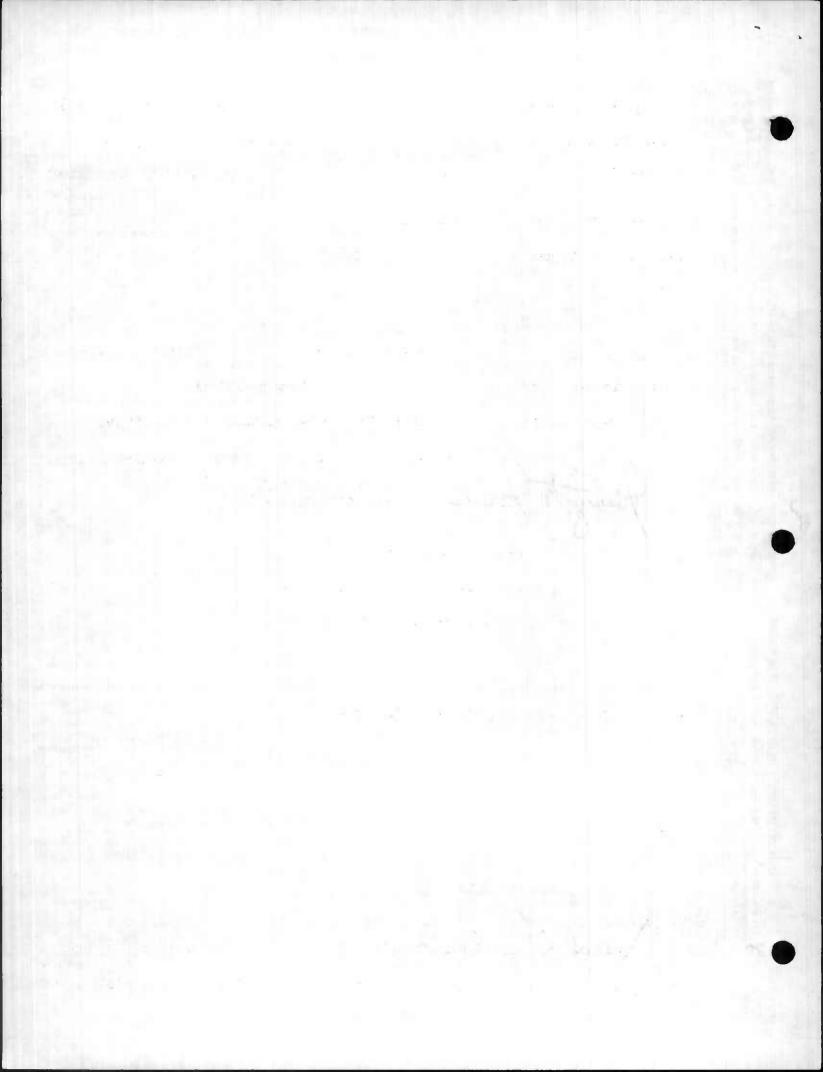
32. Registrer's Signeture

B. Sparks

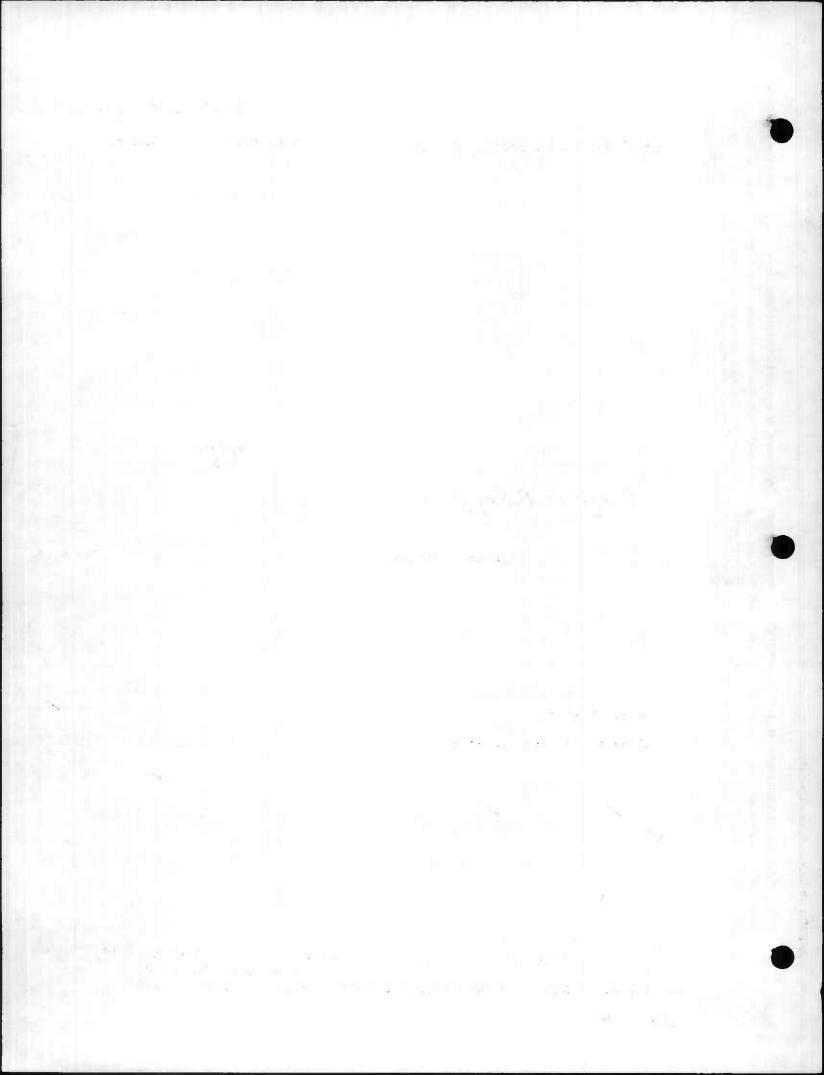


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or Attending Physician: The after death. Director, After this certificate d in by the funeral director, pa	27. Man	ner of Deeth Netural	5 Pendi		28a. Dete o (Monti	of Injury h, Dey Year)	28b. Time of Injury	f 2	Bc. Inju			d. Describe	how injury occu	rred		
Attending or death.	2 3	Accident Suicide	6 Could	tigation	nea Di	of Initial	home for			Yes 2 □ No		f Location	Street and Num	her or Du	ıral Route Number,	
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LOT	30. Nage	and address	BBB of prsor	n who comp	leted cause	e of deeth (Ite	em 23a) (Type,	Print)							20010	
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DHMH 16 Rev 6/95



	Certificate of Death	R	g. No.	40	303
	1. Decedant's Name (First, Middle, Last)	2. Data of Deat Month	h Day	Yaar	3. Time of Death
ician dical	Harold Monroe Dolan	SEPTEMB			2:45A.M
er	4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Loc	cation of Death	4c. County	of Death	
	Memorial Hospital & Medical Center Cumberl	and	A11	egany	
	5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs.	8. Data of Birth (Month, Day,	Year)	9. Birthplac	a (Stata or Foraig
	214-07-6295 83 Yrs.	Feb. 25	, 1915	Maryl	and
ŀ	Usual Rasidence of Decedant  10a. Stata 10b. County 10c. City, Town or Location			10d	Insida City Limits
					Yes 2□No
ŀ	Maryland Allegany Cumberland  10e. Street and Number 10f. Zip Coda	1	0g. Citizan of W	/hat Counity	2
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	235 Paca St. Queen City Towers 21502  11. Marital Status 12. Was Decedant Evar in U.S. 13. Wes Decedant of Hispanic Origin? (Spe	cify Yes or No-		SA - American	indian,
	Armed Forcas? If Yas, specify Cuban, Mexicen, Puarto F	Ricen, atc.)	Biac	k, Whita, atc	
	11 As 2 No Specify: 3 □ Widowed 4 □ Divorced Year or Datas: WW II		Specify.	White	
	15 Decedent's Education 16a Decedent's Usual Occupation		16b. Kind of Bu		
	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  (Give kind of work done during most of working life. DO NOT use retired)	19			
	12 Spinning		Yarn &	Fabr:	ic
	17. Fathar's Nama (First, Middla, Last)  18. Mother's Nama			Θ)	
	Vernon Dolan Maude	Shuma	ker		
	19e, Informant's Name/Ralationship (Type, Print)  19b. Meiling Address (Straet and Number or Rura	Route Number	City or Town,	Stata, Zip Co	oda)
	Ernest Riley, Jr./Funeral Dir. 230 Baltimore Ave. Cu				
ı	20a. Mathod of Disposition  1 Nama of cematary, cramatory or other place)	ept. 12,	20c. Location -	City or Town	, Stata
			Cumber	land, N	laryland
ı	21. Signatura of Funarai Service Licensee  22. Nama and Addrass of Facility  Leasure-Stein Fune	mal Hon	230 1	Raltim	ore Ave
	Ernet A. Ruley b. Cumberland Md 21	502	le 200 1	Dartini	ore Ave
	23a. Part1. Entar tha disaasa, or complications that clusad tha death. Do not antar tha mode of dying, such as cerdiac o shock, or heart failure. List only one cause on each line.	r raspiratory arr	ast,	A	proximate tarvel Between
				0	nsat and Death
ı	immediate Cause (Final disease or condition a Bilateral Pneumonia			Or	e Week
	resulting in deeth)  Due to (or es e consequence of):				
	b.				
l	Sequentially list conditions, if any, leeding to immediate cause. Entar Undarlying Causa (Diseasa or injury c.			1	
l				1	
l	Dua to (or as a consaquanca of):				
riiysiciaivm	d				
1	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.	23b. Did to	bacco usa cor	tributa to th	e causa of death
					ly 4 Unknow
	Renal Failure				
	Coronary Artery Disease	24e. Wes e		24b. Ware	autopsy tindings bla prior to
		perior	11601	comp of dea	letion of ceuse
		1 🗆 Y	s 2 No	1 🗆 Y	as 2 No
Ī	25. Was cesa rafarrad to medicei 26. Place of Death	(Check only or	a)		
	axaminar? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ inpalient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Hor			ar (Specify)	
ŀ	27. Manger of Death 28a. Dete of Injury 28b. Time of 28c. Injury at 2	28d. Dascribe h			
	1 ☑Natural 5 ☐ Panding (Month, Day Year) Injury Work? 2 ☐ Accident invastigation M 1 ☐ Yas 2 ☐ No				
	3 ☐ Suicide 4 ☐ Homlcide  Could not be detarmined  28e. Place of injury - Ai homa, farm, straat, factory, office building, atc. (Specify)	28f. Location (S City or Town		er or Rural F	louta Number,
	building, a.c. (opposity)		,,		
	29a. Certifier (Check only  1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and piece, a course of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, a course of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, a course of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, a course of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, a course of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, a course of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, a course of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, a course of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, a course of examination and/or invastigation, in my opinion, death occurred at the course of examination and/or invastigation, in my opinion, death occurred at the course of examination and/or invastigation, in my opinion, death occurred at the course of examination and/or invastigation, in my opinion, death occurred at the course of examination and occurred at the course of examination and occurred at the course of examination and occurred at the course of examination and occurred at the course of examination and occurred at the course of examination and occurred at the course of examination and occurred at the course of examination and occurred at the course of examination and occurred at the course of examination and occurred at the course of examination and occurred at the course of examination and occurred at the course of examination and occurred at the course of examination and occurred at the course of examination and occurred at the course of examination and occurred at the course of examination and occurred at the course of examination and occurred at the	and dua to the c	euse(s) and me	nner as state	ed.
	one) and mannar stated.				
	29b. Signatura and title of certifier	2	9d. Dala signe	(Month, De	y, Year)
		0.0	ptember	10,	1998
	D 33280	DE			
	30. Name and addrass of person who empleted ceuse of deeth (Itam 23a) (Type, Print) 625 Kent Avenu		te 101		
W	30. Name and addrass of person who completed ceuse of deeth (Itam 23a) (Type, Print) 625 Kent Avenu Dr. Gupta, Johnson Heights Medical Building Cumberla	ie Sui	-		
	30. Name and addrass of person who empleted ceuse of deeth (Itam 23a) (Type, Print) 625 Kent Avenu	ie Sui	te 101		



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth r 5,1998 **Physician** Henrietta Delosh September 5:45 PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Home Cove No.1, 22520 Robin Ct. Gaithersburg Montgomery | If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Dex Yeer) | Min. | Warch 28, 1892 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 2 1 F Yrs. 108-12-0564 106 New York Director Usuel Residence of Decedent the Meryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Gaithersburg 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 12 should be filed within 72 hours efter death with I. 1 and Mental Hygiene. Is marked other than "nahion" 24308 Clematis Drive 20882 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ☐ 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, spacify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 Widowed 4 □ Divorcad Whi te Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) School Teacher Elementary School 17. Fether's Name (First, Middle, Lest) 18. Mother's Nama (First, Middla, Maiden Sumeme) Be permit. Pages 1 and 2 should be Department of Health and Mental It Important: If Imm 27 is meritary or other: Jonathan Bemis Mary Donnelly 20 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Judith B. Smerlis-Granddaughter 24308 Clematis Drive, Gaithersburg, Md. 20882 20b. Pleca of Disposition (Neme of cametery, cremetory or other pleca) 20e. Mathod of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Chapel Hill Cemetery 4 □ Donation 5 □ Other (Specify) 9/18/98 Parishville, New York 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Olin L. Molesworth P.A., Funeral Home 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heerf feilura. List only dhe ceuse on each line. 20872-0117 Approximete Intarval Between Onset end Death Physician /Medical Immediete Ceuse (Final disease or condition resulting in death) INFARCTION MYOCARDIAL ACUTE Examiner Dua to (or es e consequenca of): Examiner The lew requires that the death certificete be executed buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Undarlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest and Due to (or es e consequenca of). Box 68760. physicien Physician/Medical the Due to (or as e consequenca of): signed by the e Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Minknown by 24b. Were eutopsy findings Completed 24e. Wes en eutopsy peeu eveileble prior to completion of cause of daeth? performed? pege 2 this certificate has 1□ Yes 2 No 1 ☐ Yes 2 ☐ No al or Attending Physician: T s efter deeth. I Director: After this certificet ed in by the funeral director, p 25. Wes case raferred to medical Be 26. Plece of Daeth (Chack only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P TELYes 2 No 27. Manner of Death Certification: 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Dascribe how injury occurred Netural 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Spacify) 4 Homicide filled In I To the Mospital o within 24 hours of To the Funerel D completely filled I 29a. Certifiar (Check only one) 1 Certifying Physician: To tha best of my knowledga, death occurred et tha tima, date end pleca, and dua to tha ceuse(s) and mannar as statad.

2 Hedical Examiner: On the basis of examination end/or investigation, in my opinion, daeth occurred et tha tima, data and placa, and due to tha cause(s) end manner steted. Medical 29b. Signeture and title of certified 29c. License number 29d. Date signed (Month, Dev. Year) Nama end address of person who complated cause of death (Itam 23a) (Type, Print) ERN WOO 10215 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State

Registrar

0 9 1998

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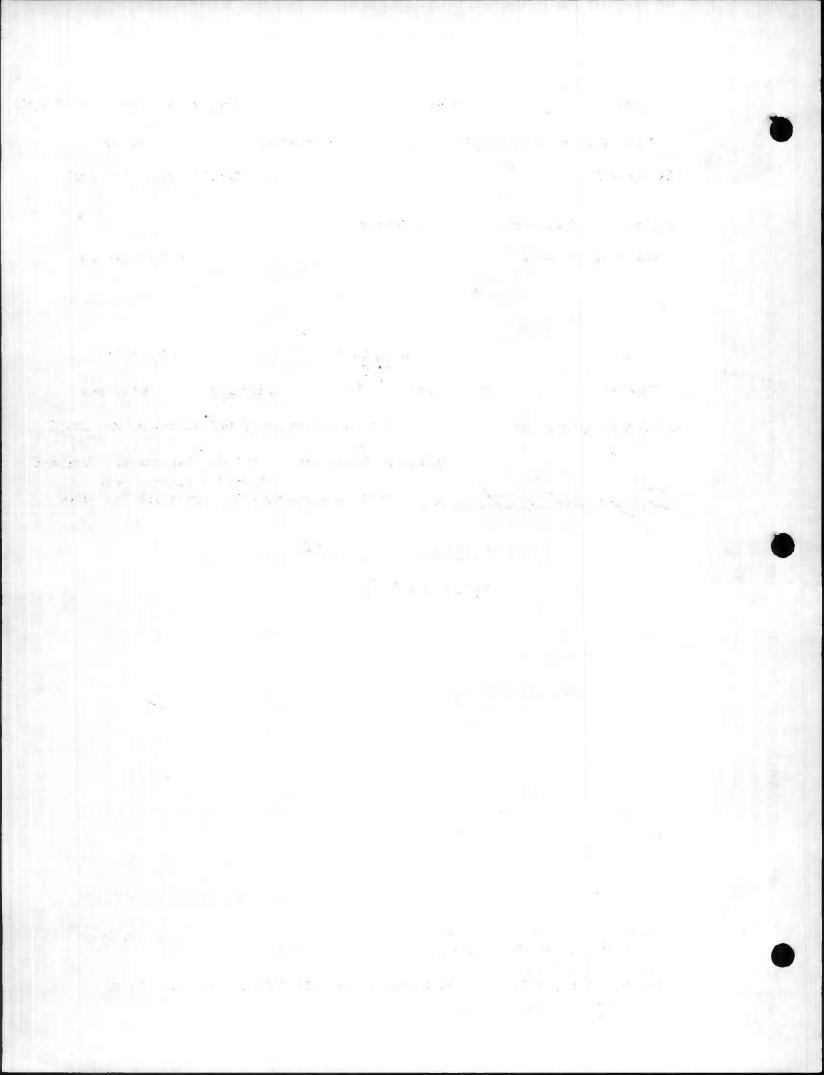
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		Decedent's Name (First, Middla,	( act)		Ce	ertificate o	f Death	2. Date of De	Reg. No.	3. Time of D
Physicia	n	Ada		Dy	ke			Month August	Day	Year
/Medica Examine		4a Facility Name (If not institution,	C. giva straat and nu				4b. City, Town, or			
LXdiffile		Frederick Mer	orial Ho	spital			Frederi	ck	Fre	ederick
Funeral			S. Sex	7. Aga (In yrs		Months Day	ar If Under 24 Hrs	8. Date of Bir	th iv, Year)	Birthplace (Stata or In Country)
Director		131-26-7695	1□M 2 <b>X</b> F	87	Yrs.			Oct.11	1	New York
and *	-	Usual Residence of Decedenf  10a. Stata 10b. County		10c. C	ity, Town or I	Location				10d. Inside City
Maryli f aho	5	2000			-					₩ Yes 2
the h	2	Maryland Fre	derick		Frede	10f. Zip Code	9		10g. Citizen of V	Vhat Country?
3m or		800 Motter	Ave.			2	1701		United	States
death	ner	11. Marital Stalus		edenf Ever in U	J,S. 13	. Was Decedenf o	of Hispanic Origin? (Suban, Mexican, Puer	Specify Yas or No	- 14. Rac	e - Amaricen Indian, k, White, etc.
ges 1 and 2 should be filed within 72 hours efter death with the Maryland it of Health and Mental Hygiens. If item 27 is marked other than "natural", or frems 23s or 28s-f show or other traumatic event, the Medical Example, must be notified at	by Funeral Director	1 Nevar Married 2 Marrie  3 Wildowed 4 Divorced		2 No		1 ☐ Yas 2 1 N		to ricall, etc.)	Specify	
2 hou	Completed	15. Decedent's	Education		16a. Dec	edent's Usual Occ	cupation	artita m	16b. Kind of Bu	usinass/Industry
Pan n	De	(Specify only highast Elementary/Secondary (0-12)	College (		lifa.	DO NOT usa rati	na during most of wo ired)	nkiig		
ed wi	0	12			Se	cretary			High :	
ould be filed with Mental Hygiene. Brked other that atic event, the	e e	17. Father's Nama (First, Middla, L	ast)				18. Mother's Na	me (First, Middla	, Maidan Suman	a)
d 2 should be filed within 72 hours eff th and Mental Hygere. 77 is marked other than "natural", or traumatic event, the Medical Exam	0	Frederick		C.	Schat			orence		ttinger
2 sho		19a. Informant's Name/Relationsh	p (Typa, Print)				eet and Number or R			
1 and Health sm 27 ther tr		William E. Dyke 20a. Melhod of Disposition	/ son	206	879	3 Inspir	ation Ave	./ Walke		Md. 21793 City or Town, Sfafa
permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other pfice.		1 ☐ Burial 2 ☐ Cremation			camatary, cr	amatory or other	place)	Date	200, Location -	City or Town, Stata
tment tant:		4 Donation 5 Other (Spi		Ha		wr Crema		9-1-98	Hagerst	own, Marylai
Deper Deper Impor any In		21. Signature of Funeral Service L	census	1		22. Name and Add	9	tauffer		
40200		Spymong	- el	ersy						,Md. 21702
Physician		23a. Part 1. Even the disease, or of shock to heart failure. List of	omplications that only one course on e	caused the dea sech line.	th. Do not e	nter the mode of c	tying, such as cardia	c or respiretory a	arrest,	Approximete Interval Betwee Onset and De
/Medical		Immediate Ceuse (Final disease or condition	15	CHEN	UC	STW	elæ			
Examiner		resulfing In death)	a.		or as a cons					
Z = .	ine		- b H	YPER	TEN?	son				1
icate be executed physician end is the bunal-transit	edicai Examiner	Sequentially list conditions,		Due to	or as a cons	equence of):				
be es ician buria	E E	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	с							
ficate be ex physician is the buna		rasulting In death) Last		Due to (	or as a cons	equence of):				
E 0.0			d							
that the death certificate be executed ed by the ettending physician end detached for use as the bunal-transit	Physiciany	Day II Other death and an allow					-to-st- Books	nah pid	***********	ntributa to the cause of
d by the detached	nys	Part II. Other algnificant condition	s contributing to di	eath out not re	suiting in the	underlying cause	given in Part I.		Yes 2 No	3 ☐ Probably 4 ☐ U
									100 2010	200
iclan: The law requires that the certificate has been signed by the frector, page 2 should be defached.	Completed by								an autopsy ormed?	24b. Were autopsy fin available prior to completion of cau of death?
a hes	E C							40	Yes 20No	1 Yes 2 N
sician: The certificate irector, pag	٥	25. Was case referred to medical					26 Place of De	eath (Chack only		10 100 ZUN
ysicla is certi directe	10 126	examiner?	Hospital:	Înpatient 2	BR/Outpati	ent 3 DOA	Other:	Home 5 Res		er (Specify)
After this funeral di		27. Mennar of Death 1 ⊠Naturel 5 □ Pending	28a. Date (Mon		28b. Time Injury	of 28c. Ir	njury at Vork?	1	how Injury occur	
al or Attending Physicien: after death. I Director: After this certific id in by the funeral director,	Certification:	2 Accident Investigation 3 Sulcide 6 Could not determine	of be 28a. Place	of Injury - At i	homa, farm, : ify)	straat, factory, offic		28f. Location City or To	(Street and Numb wn, State)	per or Rural Routa Number
1 5 4 9 (	edical Ce		xaminer: On the b	asis of examin			time, date and plac y opinion, death occ			anner es stated. and due to the cause(s)
the the		29b. Signature and title of cartifier	and man	ner stated.		29c. Lice	ense nu <i>m</i> ber		29d. Data signe	d (Month, Day, Year)
Tower		10500	11	0	1 A /	17	)2(d m	9		9(98
	-	30 Name and address of action	7 DIV	on of death (to	m 230) (Tim	o Print)	2000	-	0 1	0
		30. Name and address of person w					D / -			1700
		Joseph Ashwal		Donietrar'e Sign	THOMS	is Johnson	on Dr./ Fr	ederick	Md = 2	1/02

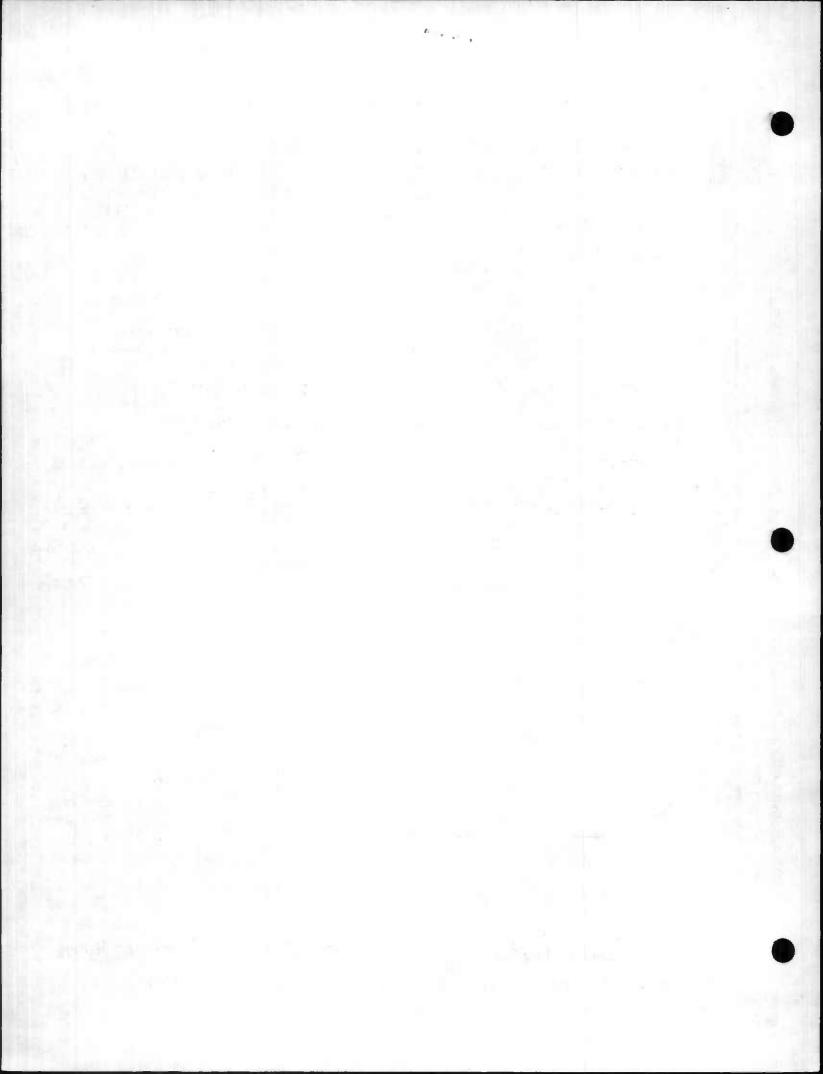
Registrar

SEP 0 1 1995 32. Registrar's Signature



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Itema	State of Maryland / Department of Health and Me 27 perPhy G763 9/22/98 EW Certificate of Death		giene Reg. No. 98	28988
	1. Decedent's Name (First, Middle, Last)	2. Date of De Month		3. Time of Death
Physician /Medical	HERBERT LEE DONAHUE		ER 03 19	
Examiner	4a Facility Neme (If not institution, give street and number)  4b. City, Town, or Loc	cation of Death	4c. County o	
84	THE JOHNS HOPKINS HOSPITAL BALTIMORE C		BALTI	IMORE
Funeral	5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birl (Month, Da	th y, Year)	Birthplace (Stete or Foreign Country)
Director	221-20-7792 62	12-18-	-1935 M	ILTON, DELAWAR
pue *	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
the Marylan 28a-f show northed at	DELAMADE GUGGERY MILLICHODO			1 ☐ Yes 2 ☐No
vith the Main or 28s-1 s	DELAWARE SUSSEX MILLSBORO  10e. Street and Number 10f. Zip Code		10g. Citizen of W	hat Country?
	8 CRICKET STREET 19966		100	
r thems 23	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sper	cify Yes or No		- American Indien,
or he	Armed Forces? If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black	, White, etc.
by	If Yes, Give 1 ☐ Yes 2 ☐ No Specify:  3 ☐ Widowed 4 ☐ Divorced Yeer or Detes:		Specify:	WHITE
ed within 72 hours yglene. er than "natural", f, tre Medical Ex-	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grede completed) (Give kind of work done during most of workin	na .	16b. Kind of Bus	
d within 72 hours of glone. It than "natural", or the bedden from the completed by I	Elementery/Secondery (0-12) College (1-4or 5+)		AUTOMOTI	
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Be every	17. Fether's Name (First, Middle, Last)  18. Mother's Neme	(First, Middle,	Maiden Sumeme	)
d 2 should be filed the and Mental Hygi 7 is marked other treumatic event, To Be Co	ROBERT DONOHUE KATHERIN			
10 0 0	19e. Informant's Name/Relationship (Type, Print)  WILSTE DONOHUE / LITEE  #8 CRICKET ST MILLSBOR			stete, Zip Code)
CENL	Walled of Disposition (Name of	Date Date		City or Town, Stete
00-1	1 Burial 2 Cremetion 3 Removal from State MFI. SON S CAPE HENT OPEN			
semit. Peg Separtment mportant: I any injury o		3/98	FRANKFOR	D, DELAWARE
Departi Departi Importi any in	21. Signature of Edinard Service Honorae  22. Name end Address of Facility  MELSON FUNERAL SER	VICES		
	43 THATCHER STREET	. FRAN	KFORD, DE	
	23a. Part 1. Enfer the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or shock, or heart failure, just only one ceuse on each line.	r respiratory e	rrest,	Approximete Interval Between Onset end Deeth
Physician /Medical	Immediate Cause (Final Bases Tuga 2002)			2 -3 -0.18
Examiner	disease or condition POWEL PRINTIE (700)			23 4793
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executed n and ial-transit Examine	b	931		1 ( )///
exec in an rial-tr	If eny, leading to immediate			
cate be executed obtassical and the burial-transit dical Examir	Cause (Disease or injury C			
	resulting in death) Last			
death certific e stiending p ed for use as	d			
the att hed fo	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did	tobacco use con	tribute to the cause of death?
± >0 F		10	Yea 2 No	3 □ Probably 4 Unknow
es the				
The law requires that cale has been signed by page 2 should be determined.			en eutopsy rmed?	24b. Were autopsy findings aveilable prior to
hes be ge 2 sh mple		le de		completion of cause of death?
The la		10	Yes 2000	1 ☐ Yes 2 ☐ No
certificate rector, per	25. Was case referred to medical againiner?	(Check only	one)	
Z 0 0	1 Nospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor	ne 5□Resi	dence 6 Othe	r (Specify)
ding Ph h. After th funeral	1 🖄 Natural Strending (Month, Dey Year) Injury Work?	8d. Describe	how injury occurre	d
Attending or death.  actor: After by the fune fune fillication	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be			
tal or Attending P at State that the funering the funering the funering the funering Certification:	determined  determined  determined  determined  28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)	City or To		r or Rural Route Number,
oral Ce				
he Hospital in 24 hours he Funeral pletely filled edical Co	29e. Certifier  (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and check only one)  2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the d et the time,	cause(s) and mar date end pleca, a	nner as stated. nd due to the ceuse(s)
To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b Medical Certi	one) end menner stated.  29b. Signature and title of certifier 29c. License number		29d, Date signed	(Month, Dey, Year)
5 × 5 8				
	Panda a. Lipsettino DOO-38261		4 PIEMP	er 4,1998
6	30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)  TAMELA A. LIPSETT GOON WOLFE Street BALTIMORE	MO	21287	
State Registrar	31. Dete filed (Month, Dey, Year) SEP 0 9 1998  32. Registrar's Signature  Sparks			



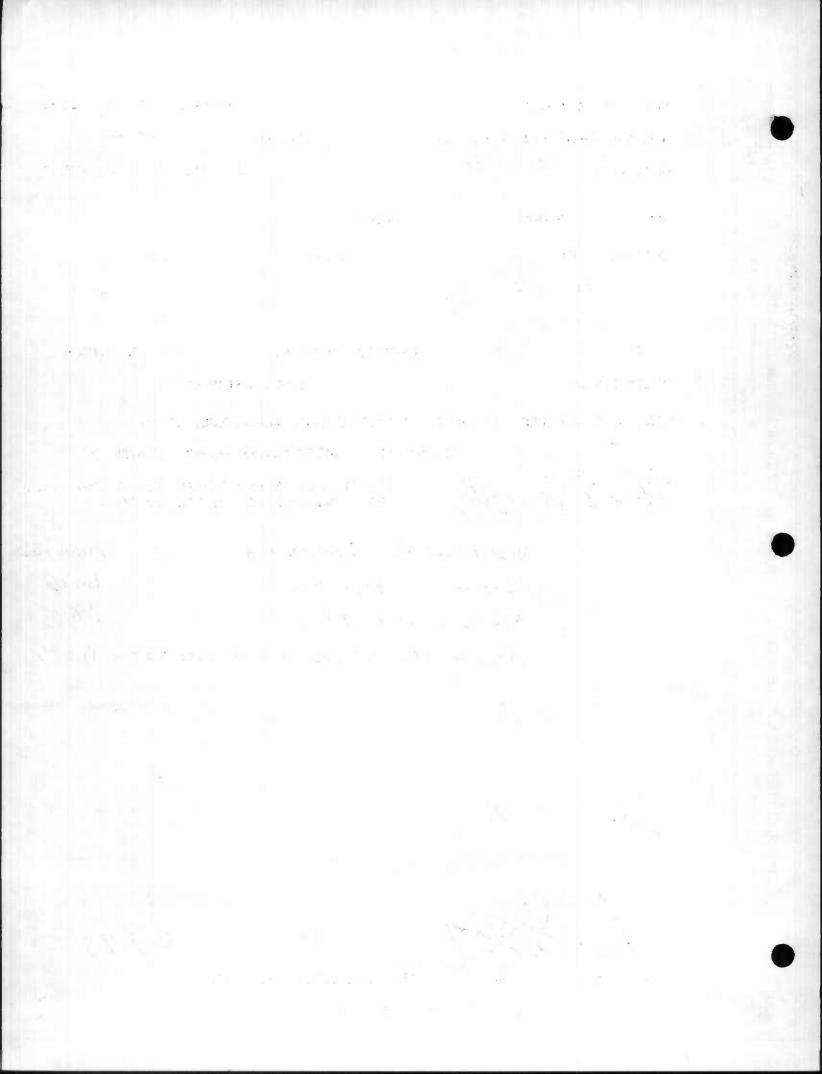
# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28989

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Oykman Edward

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day **Physician** September 07,98 1640 EDWARD FRANK DYKMAN /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Easton Memorial Hospital Easton Talbot 8. Date of Birth (Month, Day, Year) APR. 24, 19 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Min. Months Days 1 MM 2□ F 79 NEW JERSEY Director 149-10-6691 Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examinar must be notified at 1 TYas 2 No Director TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3 CURZON COURT Funeral 21601 USA 12. Was Decedant Evar In U,S. Armed Forces? 1 ₭ Yes 2 □ No if Yes, Give Was Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 200 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Year or Dates:WW II Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry I Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w Department of Health and Mentel Hygiens Important: If item 27 is marked other that any injury or other traumetic ex--0-CHEMICAL OPERATOR PERFUNE/COLOGNE 17. Father's Name (First, Middla, Last) 18. Mother's Neme (First, Middla, Malden Surname) Be AUGUST DYKMAN WANDA MARKOVICH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PAMELA A. GREENFEDER / DAUGHTER 34 GAISLER ROAD, BLAIRSTOWN, NJ 07825 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other of 20c. Location - City or Town, Stata Date 1 Burial 2X Cremation 3 Removal from State CHESAPEAKE CREMATION CENTER 9-9-98 CHESTER, MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Lic 22. Nama and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner ESPIRATORY that the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in daath) Last and bunial-tran physician Physician/Medical the Due to (or as a consequence of) ADRITIC ANEURYSM REPAIR 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. been signed by the should be dateched 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No by 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? certificata has 2 XNO 1 Yes 1 TVes 2 No Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica Be 25. Was cese referred to medical axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 2 ER/Outpatient 3 DOA 27. Manper of Deat funeral Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No completaly filled in by the 3 Suicida 6 ☐ Could not be determined 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 C Homicide edical 1 Cartifying Physic an: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated 2 Medical Examine, on the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a, Certifier con the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapper stated. Vithin 2 29b. Signature of title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D48064 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) KEVIN STITLEY, M.D., 505 DUTCHMAN'S LANE, EASTON, MD 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			Otate of Mary		cate of		R	eg. No.	28	992
Pi	hysician	1. Decedent's Nama (First, Middle, Li					2. Date of Deal Month	Day	Year	3. Time of Death
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	neral ector	5. Social Security Number 6. 212-50-9846		rrs. last birthday) If t	Under 1 Year onths Days		8. Dale of Birth	Year)	9. Birthplac	TOWN, MD
anylend	T dat	Usual Residence of Decedent  10a. State  10b. County		City, Town or Location	n				10d	I. Inside City Limits 1  Yas 2 □ No
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with t	5 5	10e. Streel and Number	ADT 1	10	of. Zip Code 21789			U. S.		/ (
w Heeth w	era	22 CARROLL ST.	12. Was Decedent Ever i	n U.S. 13. Was I			Specify Yas or No- rto Rican, atc.)		- American	Indian,
vithin 72 hours efter deeth with the Maryland ene.	0 5		Armed Forces?  1  Yes 2 No If Yes, Give Year or Datas:		s, specify Cub		rto Rican, atc.)	Specify:	, Whita, ald	
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and 2 salth ar	rtrau	KARLA JEAN ESHELI				. APT. 1				
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0 822	= 5	1 Burial 2 □ Cremation 3 [ 4 □ Donation 5 □ Other (Speci		MMITSBURG			98 F	MMITSBUR	G. ME	).
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deet	shed for	Part II. Other significant conditions	contributing to death but not	resulting in the underly	ying ceuse gi	ven in Part I.	23b. Did to	obacco use con	tribute to t	he causs of death
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of VItal Records, P.O. Box Physician: The law requires that the death cert	S C/ D						24a. Was a perfor	an autopsy med?	com	a autopsy findings able prior to pletion of causa eath?
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O ding	fune	1 (DNatural 5 Panding 2 Accident Investigation	28a. Data of Injury (Month, Day Yea	r) Injury	28c. Inju Wo	ork? ]Yes 2□No	200. Dascribe in	ow injury occurre	,	
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,		30. Name and address of person who KANAN HUDHUD, I	complated causa of daath (	Item 23a) (Type, Print HOUSE AL	ENUE	,D3 F				
	State	31. Date filed (Month, Day, Year)	32. Registrar's S		,					

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State of Maryland / Department of Health and Mental Hygiene

							Certific	ate of	Death		Reg. No.	0 %	0991
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Exami	ner	Rockville							Rockv			gomer	V
Funeral Director	Г	5. Sociel Security Number 216-40-678	6. Se	_	7. Age (in	yrs. lest birt	hdey) If Un Monti	der 1 Yeer hs Days		8. Date of Bird (Month, De Feb. 22		_	ce (State or Foreig
dand ow		Ususl Residence of Deced 10e. Stete 10b. 6	ent County		10	c. City, Town	or Location					100	d. Inside City Limit
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r 284	irec	10e. Street and Number	-				10f.	Zip Code	· · · · · · · · · · · · · · · · · · ·		10g. Citizen of V	Vhet Countr	y?
th wit	a D	9517 Neuse	Way					22066	5		USA		
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2 sho and 1 is me		19e. Informant's Name/Re	lationship (T)	vpe, Print)		19b.	Mailing Addr	ess (Street	end Number or Ru	ral Route Numbe	er, City or Town,	Stete, Zip C	Code)
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State of Maryland / Department of Health and Mental Hygiene

nend: #23a Part	Ia Per MD Film G763 9-23-98	certifi	cate of Death	Reg. No.	28993
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Funeral Director	719 G/EN DRI 5. Social Security Number 6. Sex 212-26-4018 1 M 20	7. Age (In yrs, last birthdey)	WESTMI	NSTER CAR  Dete of Birth (Month,/Dey, Year)  9	Birthplece (State or Foreign Country)
the Maryland 28a-f show cultified at	Usual Residence of Decadent  10e. Stete 10b. County  APROLL	10c. City, Town or Location	······································		10d. Inside City Limits
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	15. Decedent's Education (Specify only highest grede comp  Elementery/Secondary (0-12)  Col	leted) 16e. Decadent's (Give kind	s Usuel Occupetion of work done during most of working (OT use retired)  # SA/ESMAN	16b. Kind of Busin	ess/Industry
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Baltimoperation Page Department Important: Important: I any Injury of once.	21. Signature of Funerel Servica Licansee	e) 412	The end Address of Fecility Fifther WAShing To N R	5 FUNECAL H	OME & Chapele
Physician /Medical Examiner	23a. Party. Enter the disease, or complications speck, or heart fellure. List only one cause Immediate Ceuse (Finel disease or condition resulting in death)	ETASTATIC  Due to (or es e consequence	COLON C	A	Approximete Intervel Between Onset and Death
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cords, requires been sign should be				24e. Wes en eutopsy performed?	24b. Were eutopsy findings eveileble prior to completion of cause of death?
f Vital Recystoin: The law s certificate has director, page 2	25. Wes case referred to medical		26. Plece of Deeth (C	1□Yes 2ŪNo	1 □ Yes 2 100
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State Registrar	SEP 0 9 1998	32. Registrer's Signature	Spark		

E. W. L. Hilles Fred March 2011 1 62 Min 2 16 1 18 18 2 LL A Comment of the Comment of We will be the second Spiral partir Brack Salescope Wall FORT FACT WINE OF FEED JOINER WINDERS IN SHEET 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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Funer Directo		5. Social Security I 358-52-		Sex 1∏M 2□F	7. Age (In yrs. la 40	st birthday) Yrs.	If Under Months	1 Year Deys	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da DEC. 1	y, Year) 4,1957	9. Birthi Cour TLI	place (State or Foreign htry) LINOIS
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ter dee Itema	by Funeral Director	11. Marital Status 1 Never Mari	rried 2 Married	12. Was Deced	dent Ever in U,S ces? 2 No 198	00	Was Deced I Yes, spec	ent of H ify Cuba		gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		ck, White,	an Indian,
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cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Last Physician/Medicai

MITRAL VALVE DISEASE Due to (or es e consequence of):

YEARS

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Ĭ Unknown

3. Time of Death

24b. Were autopsy findings eveilable prior to completion of cause of deeth?

24e. Wes an autopsy performed? 1 Yes 2 No

1 ☐ Yes 2 No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2♥ No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work?

27. Manner of Deeth 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

tX Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) end manner as stated.

2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29d. Date signed (Month, Day, Year) 29b. Signal 29c. License number 0038915 (WI) SEPT 8

ed cadse of death (Item 23a) (Type, Print) 30. Name end andress of person

NATIONAL NAVAL MEDICAL CENTER

A.CHAO, LT, MC, USN 31. Date filed (Month, Day, Year)

SEP 1 1 1998

BETHESDA MD 20889-5600

State Registrar

32. Registrer's Signeture souls

Division of Vital Records, P.O. Box 68760

The lew requires that the deeth certificate be e

ettending physician for use es the burie

been signed by the should be deteched I

page 2

certificate

To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, t

by

Completed

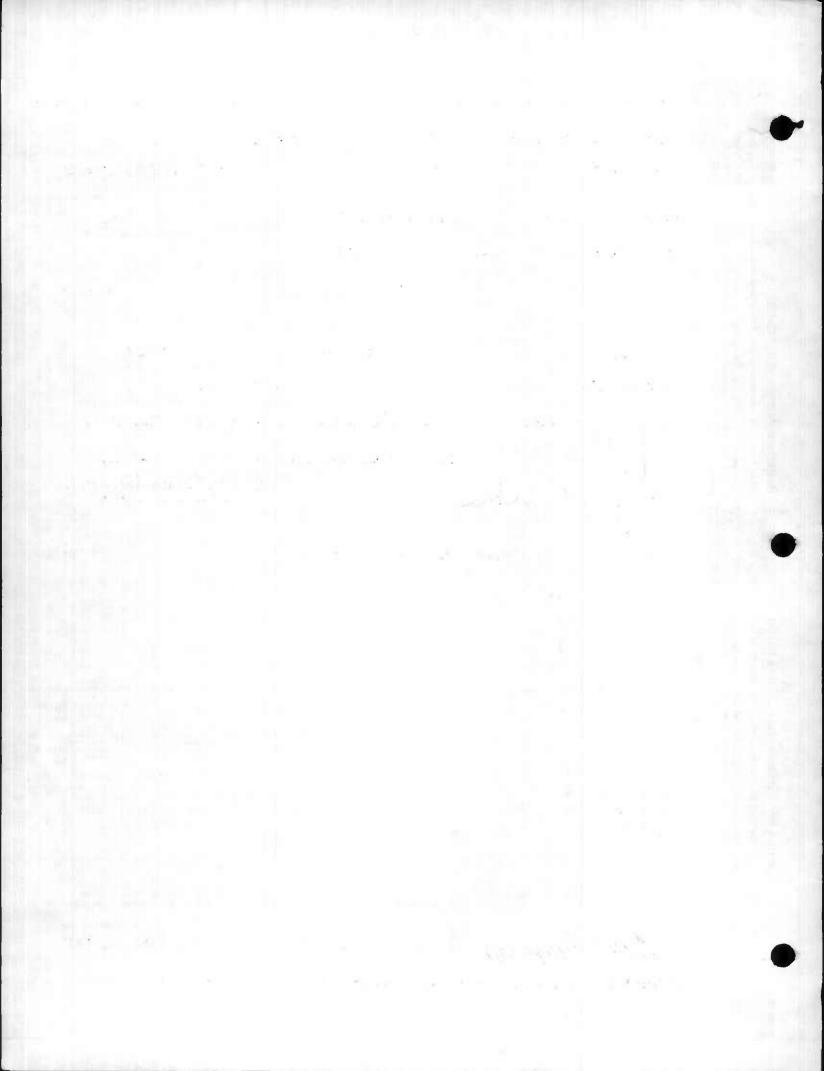
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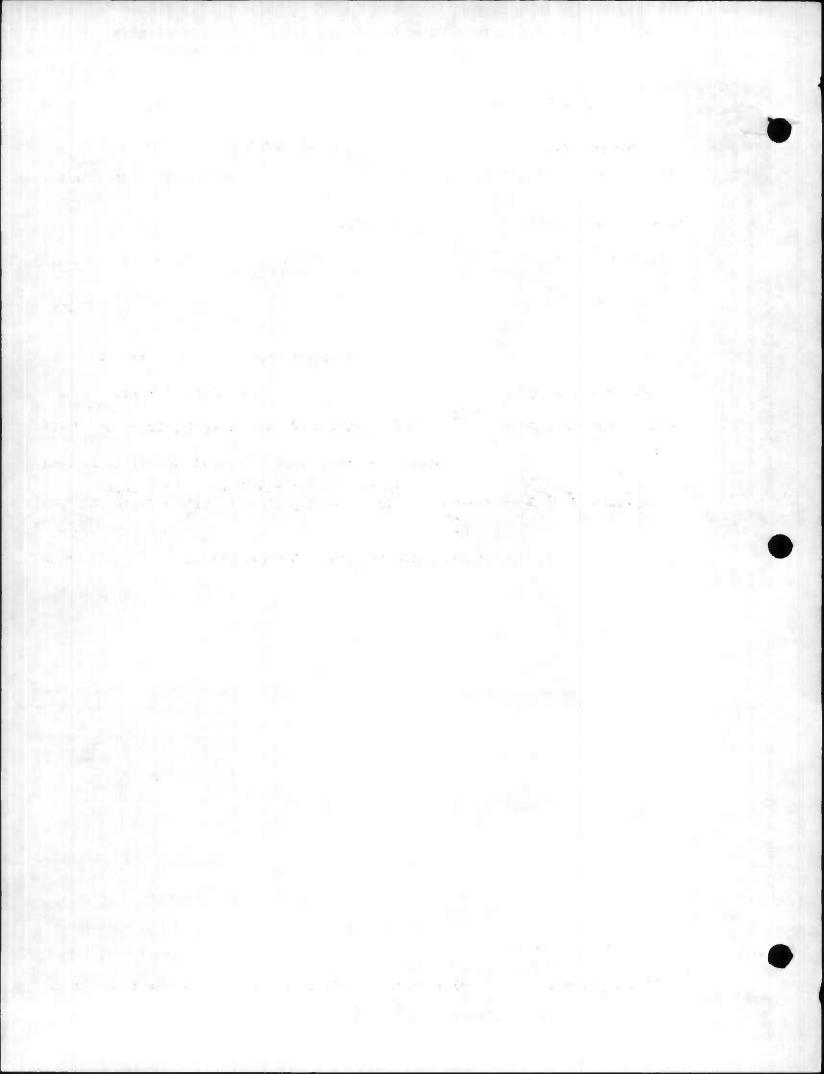
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Deta of Death 3. Time of Deeth 1 Decedent's Nama (First Middle Last) Dey **Physician** SEPT. 5, 1998 MICHAEL FLEISCHER 11:30AM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not institution, give street and number) Examiner HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) FEB. 27, 1908 If Under 1 Year Birthplece (State or Foreign Country)
 CT 5. Social Security Number 6. Sax 7. Age (In yrs. last birthdey) **Funeral** Months Deys 1 X M 2□ F 90 Yrs 579-54-4220 Director Usual Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Example: must be notified at 1 Yes XX No Directo MD MONTGOMERY ROCKVILLE 10e Street and Number 10f, Zip Code 10g. Citizen of Whet Country? 20852 6121 MONTROSE RD. USA Funeral death 12. Wes Decedent Evar In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Merital Status Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours efter to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examples page. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) MINERALOLOGIST GOVERERNMENT RESEARCH 18. Mothar's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be JULIUS FLEISCHER FLORA REINITZ 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) WALTER FLEISCHER / SON 7318 HOOKING RD., MCLEAN, VA 22101 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) KING DAVID MEMORIAL GARD 9/9/98 FALLS CHURCH, VA 21. Signature of Euneral Sportse Liopesee 22. Name and Address of Fecility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 DANIEL SIMONS on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, 23e. Pert1. Enter the discusses Approximete Interval Between Onset end Death Physician Immediate Ceuse (Final diseese or condition resulting in deeth) SEPSIS /Medical WEEK Examiner Due to (or es e consequença of): Physician/Medical Examiner ULCERS PRESSURE INFECTED The law requires that the death certificate be executed physician and s the buriel-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieled events resulting in deeth) Last Records, P.O. Box 68760. Due to (or es a consequenca of) 1 50 980 50 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown ALZHEIMER'S DIS EASE þ 24b. Were autopsy findings available prior to 24e. Was en autopsy performed? Completed completion of cause of deeth? certificate ha 2 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: Be 25. Wes case referred to medical 26. Pleca of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 45 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yes 2 No After this funeral 28d. Describe how Injury occurred 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury Certification: 28c. Injury et Work? or Attending s efter des. 1 Naturel 5 Pending Investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide • Funeral Dire letely filled in b 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steled.
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pieca, and due to the cause(s) end menner stated. 29e. Certifier edical (Check only one) 29b. Signeture end title of continu 29c. License number 29d. Date signed (Month, Dey, Year) STAFF Physician 70 D18084 8 ,1998 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) D.D. PATEL, MD, 6121 MONTROSE RD., ROCKVILLE, MD 20852 31. Data filed (Month, Dey, Year) 32. Registrer's Signeture State SEP 09 1998 Registrar

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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

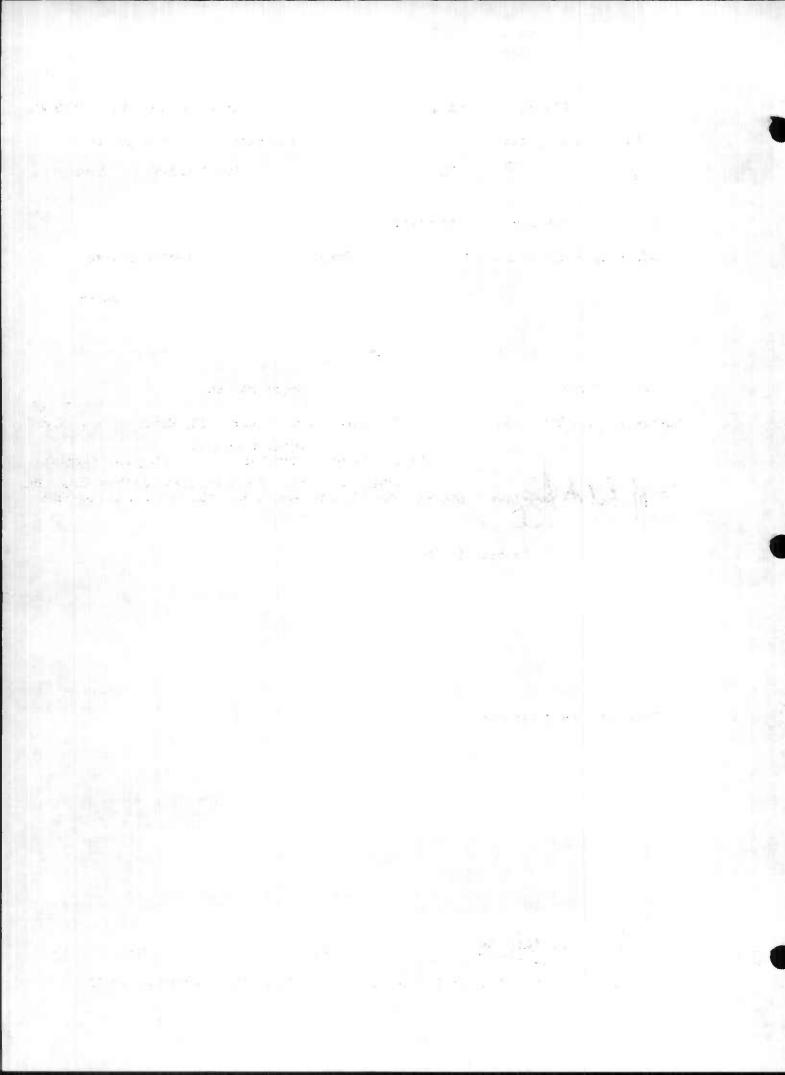
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State of Maryland / Department of Health and Mental Hygiene

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Funeral Director	5. Social Security Number 6. Sex 578–54–0498  Usual Residence of Decedent	7. Age (In y.	o. radi birtirday/	Under 1 Year onths Deys		8. Date of Birth (Month, Day, ) May 9, 1	906	9. Birthplace ( Country) IOWa	Stete or Foreign
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of Henry roth	20e. Method of Disposition  1 XBurial 2 Cremation 3 Re	20t	<ul> <li>Place of Disposition</li> <li>cometery, cremate</li> </ul>	on (Name of ory or other pl	ece) September	16, 1998	c. Location -	City or Town, S	tate
Pag nent int: ii	4 Donation 5 Other (Specify)	A	rlington	Nation	al Cemete		rlingt	on, Vir	ginia
permit. Pages 1 and Department of Health Important: If Item 27 eny injury or other tr ence.	1. Signeture of Furieral Service License	_	Robe 1846 7557	ame and Addr	ress of Facility Limphrey Fun- Sin Avenue,	eral Home/B	ethesda	-Chevy Ch	ase, Inc.
	23a. Part1. Enter the disease, or compositions shock, or heert feilure. List only	74.			-		_		oximete
/Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in death) a	Septic Sho	ock o (or es e consequer	nce of):					
ficate be executed physician and is the burist-transit edical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	Due to	(or es e consequer	nce of):	154	4			1 73
E 010	that initiated events resulting in death) Last		(or as a consequen	ce of):	1			and only and	
attend for use									
at the death cert of by the attendin stached for use Physician/N	Pert li. Other significant conditions cont	tributing to death but not	resulting In the unde	rlying ceuse g	iven in Part I.	23b. Dld tob	acco usa co	ntribute to the	cause of death?
gned by be detected by Phy	Coronary Artery	Disease				1 Yes	2K) No	3 Probably	4 Unknown
The law requin state has been single 2 should Completed					100 V	24a. Wes an perform	eutopsy ed?	evailebio	utopsy findings e prior to ion of ceuse ?
The law requinities has been a page 2 should						1 ☐ Yes	2 X No	1 ☐ Yes	2□ No
sentifica color, Be C	25. Wes cese referred to medicel examiner?				26. Place of Dee	eth (Check only one	)		
hyale lis ca I dire To E	1 X Yes 2 No	lospital: 1   Inpatient 2	XER/Outpetient	3 DOA	ther: 4 Nursing H	lome 5 Residen	ce 6 □Oth	er (Specify)	
	27. Menner of Deeth 1 X Neturel 5 ☐ Pending	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Inj	ury at ork?	28d. Describe hov	injury occur	red	
tal or Attending P is after death. In Director: After I ad in by the funer: Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide	28e. Piace of Injury - A building, etc. (Spe	t home, farm, street,	M 1[	☐ Yes 2 ☐ No	28f. Location (Stre City or Town,	et and Numb State)	per or Rural Rou	te Number,
Hospi 24 hour Funer ptely fill dical		sician: To the best of my lener: On the basis of exemand manner stated.							
To the To the comple	29b. Signeture and title of certifier	4 4 0		29c. Licer	nse number	29	d. Date signe	d (Month, Dey,	Year)
20	J. Char				2578	S	eptemb	er 10,	1998
	30. Name and address of person who con Gul Chablani, M.D				l6, Rockvi	ille, Mary	land	20852	
State	31. Date filed (Month, Dey, Year)	32. Registrer's Sig		doo	1.1				



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Physician	ı
/Medical	Ļ
Examiner	4
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**Funeral** Director

the Maryland 28a-f show 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified as With death o filed within 72 hours efter of Hygiana. permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other traumatic event, pages.

Baltimore, Maryland 21215-0020

**Physician** /Medical Examiner

The law requires that the death cartificate be executed buriel-transit and physician s the buriel-Box 68760. as attanding ō ed by the s Division of Vital Records, P.O. signed by t d be datect peen hes paged certificata or Attending Physicien: this funaral After after death. filled in by • Funeral C Hospital plately To the Vithin 2

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year September 9, 1998 9:25 AM Tilde Corinne Pellegrini Ferretti 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Shady Grove Adventist Nursing Center Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Yeer) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1□M 2\ F Days December 28, 1908 89 New York 051-14-5712 Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d Inside City Limits 1X Yes 2 No Directo Virginia Prince William Manassas 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10671 Blendia Lane #4 20109 United States Funeral 12. Was Decedent Ever In U.S. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Detes: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify ģ 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry 15. Dacedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maidan Sumama) 17. Father's Name (First, Middle, Last) Be Pietro Pellegrini Amelia Allegretti 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1704 Pitt Place, Rockville, Maryland 20850 Vincent E. Ferretti, Jr./son 20b. Place of Disposition (Name of cemetary, cramatory or other place) September 12, 1998 20c. Location - City or Town, Stete 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Peter's Cemetery St. Staten Island, New York 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. M00831 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or haart failure. List only one causa on each lina. Approximete Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting In daath) Dehydration Days Due to (or as a consequence of) Examine Congestive Heart Failure Years Due to (or es a consequence of) Sequentially list conditions, if any, leading to Immediata ceusa. Entar Undarlying Cause (Disease or injury Hypertension Years Physician/Medicai that initiated evants resulting in death) Last Due to (or as a consequence of): Coronary Artery Disease Years 23b. Dfd tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings evailable prior to completion of ceuse of death? Completed 24a. Was an eutopsy performed' 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Be 25. Was cese referred to medical 26. Place of Death (Check only ona) Other: 4X Nursing Home 5 Rasidance 6 Other (Specify) 2 1 Tyes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. fnjury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida 29a. Cartifian 1 🕰 Certifying Physicien: To tha bast of my knowladga, daath occurrad at tha tima, data and place, and due to tha causa(s) and manner as steted. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) D43272 September 9, 1998 30. Nama and addrass of person who completed ceuse of death (Item 23a) (Typa, Print)

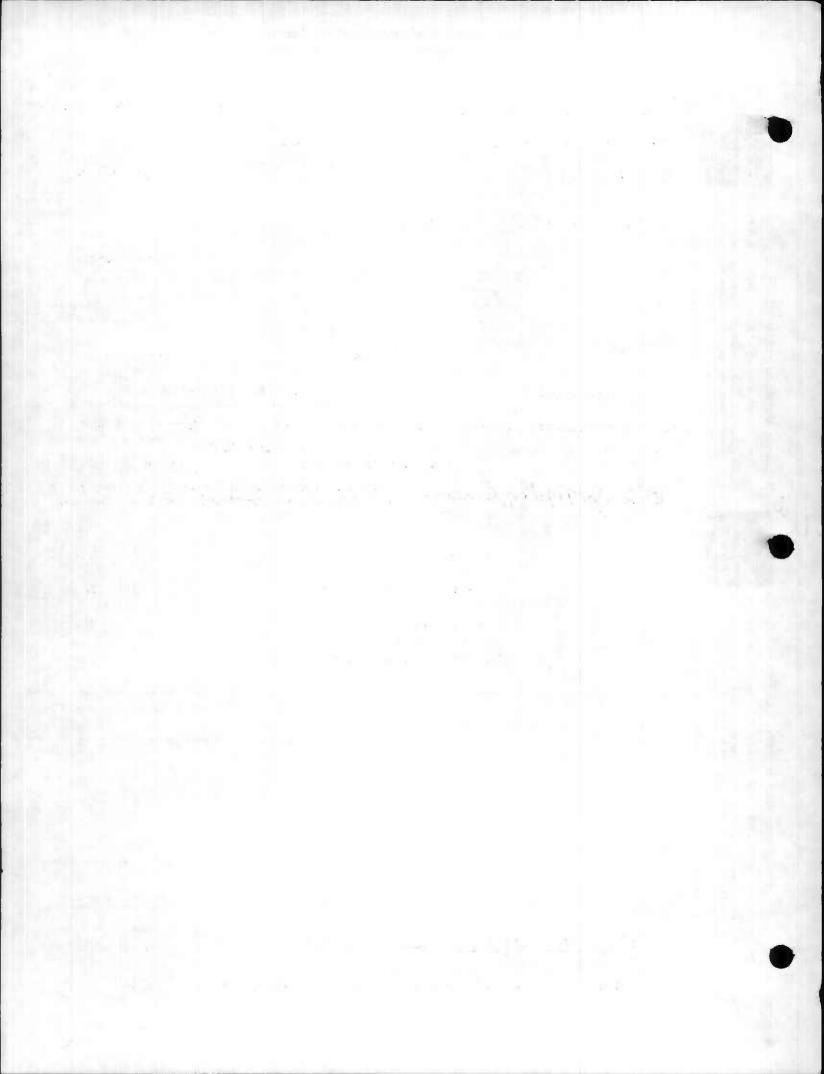
809 Veirs Mill Road, Rockville, Maryland 20851

State Registrar Sunita Hanjura, M.D.

SEP 1 1 1998

32. Registrar's Signeture

31. Date filed (Month, Dey, Year)



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1, Decedent's Nama (First, Middla, Last) Ellen 2. Dete of Death 3. Time of Death Month Day September 2, **Physician** Alverta FALCONER 1998 1:00 am /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Homewood Retirement Center Frederick Frederick 5. Social Sacurity Number If Undar 1 Year | If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days 1 M 25 F 97 Months Hours 212-38-7507 Director Jan. 28, 1901 Pennsylvania Usual Rasidance of Dacedant death with the Marylend 10b. County 10c. City, Town or Location show 10d. Insida City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Frederick Frederick 1 Yas 2 No Director 10e. Street and Number 1900 Rosemont Avenue 10f. Zip Coda 10g. Citizan of What Country? 21702 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2X No If Yas, Giva 13. Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian. 11. Marital Status Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mentel Hygians. Important: If Item 27 is marked other than "natural; or ite any finury or other traumatic event, I'm Medical Earning. 1 Navar Marriad 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: à White 3 Widowad 4 □ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decadent's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Teacher Public School System 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumema) Be William L. Comer Prudence A. Riffle 2 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)
616 Hawsesbury Terrace, Silver Spring, MD 20904 19a. Informant's Name/Ralationship (Type, Print) William C. Falconer/Son 20b. Piace of Disposition (Nama of 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Mt. Ulivet Cemetery 1 Dourlai 2 Cramation 3 Ramoval from Stata Sept. 5, 1998 Frederick, MD 4 ☐ Donation 5 ☐ Othar (Spacify) 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Keeney & Basford P.A. Funeral Home 106 E Church Street, Frederick, Maryland 21701 23a. Part1. Enter the disaasa, or complications that Laused the death. Do not anter the mode of dylng, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one ceuse do aach line. Approximata Intarval Batween Onset and Death Physician /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Examiner attending physician end for use es the burial-transit Sequantially list conditions, if any, laading to immadiata ceusa. Enter Undarlying Cause (Disaasa or injury tha daath certificate be axec Physician/Medical that initiated avants resulting in daath) Last Dua to (or as a consequence of) P.O. ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 20 3 Probably 4 Unknown ate has been signed I page 2 should be det Records, by 24b. Wera autopsy findings availabla prior to complation of ceusa of daath? Completed 24a. Was an eutopsy 2 No certificate 1 Yas Division of Vital Be 25. Wes casa rafarred to madicel 26. Placa of Death (Check only one) axaminer 1 Yaa 2 Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Affer 1 Netural 2 Accidant 5 Panding invastigation Injury death. 1 Yas To the Hospital or Attendi within 24 hours ettar death To the Funeral Director: A completely filled in by the fi 6 Could not be datarmined 3 Suicide 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homleida Certifying Physician: To the bast of my-knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stetad. 29a. Cartifian edical (Check only one) 29b. Signatura and title of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Neme and eddrass of person who d cause of death (Item 23e) (Type, Print) th St. Frederick, mo Kober mann mp. 300 W 31. Data filad (Month, Day, Year) 32. Registrer's Signatura State SEP 04 1998 Registrar

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Mary Track College